Y4. Ap6/1:L11/987/pt.3

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES APPROPRIATIONS FOR 1987

ORIGINAL

COMPLETED

1073

HEARINGS

BEFORE A

SUBCOMMITTEE OF THE

COMMITTEE ON APPROPRIATIONS

HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

SECOND SESSION

SUBCOMMITTEE ON THE DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES

WILLIAM H. NATCHER, Kentucky, *Chairman*

NEAL SMITH, Iowa
DAVID R. OBEY, Wisconsin
EDWARD R. ROYBAL, California
LOUIS STOKES, Ohio
JOSEPH D. EARLY, Massachusetts
BERNARD J. DWYER, New Jersey
STENY H. HOYER, Maryland

SILVIO O. CONTE, Massachusetts
GEORGE M. O'BRIEN, Illinois
CARL D. PURSELL, Michigan
JOHN EDWARD PORTER, Illinois
C. W. BILL YOUNG, Florida

HENRY A. NEIL, JR., FREDERICK F. PFLUGER, ROBERT L. KNISELY, MICHAEL A. STEPHENS, and BETTILOU TAYLOR, *Subcommittee Staff*

PART 3

HEALTH

(Except National Institutes of Health)

	Page
Health Resources and Services Administration	1
Alcohol, Drug Abuse, and Mental Health Administration	257
Centers for Disease Control	537
Office of the Assistant Secretary for Health	749

Printed for the use of the Committee on Appropriations

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES APPROPRIATIONS FOR 1987

HEARINGS

BEFORE A

SUBCOMMITTEE OF THE

COMMITTEE ON APPROPRIATIONS

HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

SECOND SESSION

SUBCOMMITTEE ON THE DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES

WILLIAM H. NATCHER, Kentucky, *Chairman*

NEAL SMITH, Iowa
DAVID R. OBEY, Wisconsin
EDWARD R. ROYBAL, California
LOUIS STOKES, Ohio
JOSEPH D. EARLY, Massachusetts
BERNARD J. DWYER, New Jersey
STENY H. HOYER, Maryland

SILVIO O. CONTE, Massachusetts
GEORGE M. O'BRIEN, Illinois
CARL D. PURSELL, Michigan
JOHN EDWARD PORTER, Illinois
C. W. BILL YOUNG, Florida

HENRY A. NEIL, JR., FREDERICK F. PFLUGER, ROBERT L. KNISELY, MICHAEL A. STEPHENS, and BETTILOU TAYLOR, *Subcommittee Staff*

PART 3

HEALTH

(Except National Institutes of Health)

	Page
Health Resources and Services Administration	**1**
Alcohol, Drug Abuse, and Mental Health Administration	**257**
Centers for Disease Control	**537**
Office of the Assistant Secretary for Health	**749**

Printed for the use of the Committee on Appropriations

U.S. GOVERNMENT PRINTING OFFICE
59-781O WASHINGTON : 1986

I

COMMITTEE ON APPROPRIATIONS

JAMIE L. WHITTEN, Mississippi, *Chairman*

EDWARD P. BOLAND, Massachusetts
WILLIAM H. NATCHER, Kentucky
NEAL SMITH, Iowa
JOSEPH P. ADDABBO, New York
SIDNEY R. YATES, Illinois
DAVID R. OBEY, Wisconsin
EDWARD R. ROYBAL, California
LOUIS STOKES, Ohio
TOM BEVILL, Alabama
BILL CHAPPELL, Jr., Florida
BILL ALEXANDER, Arkansas
JOHN P. MURTHA, Pennsylvania
BOB TRAXLER, Michigan
JOSEPH D. EARLY, Massachusetts
CHARLES WILSON, Texas
LINDY (MRS. HALE) BOGGS, Louisiana
NORMAN D. DICKS, Washington
MATTHEW F. McHUGH, New York
WILLIAM LEHMAN, Florida
MARTIN OLAV SABO, Minnesota
JULIAN C. DIXON, California
VIC FAZIO, California
W. G. (BILL) HEFNER, North Carolina
LES AuCOIN, Oregon
DANIEL K. AKAKA, Hawaii
WES WATKINS, Oklahoma
WILLIAM H. GRAY III, Pennsylvania
BERNARD J. DWYER, New Jersey
BILL BONER, Tennessee
STENY H. HOYER, Maryland
BOB CARR, Michigan
ROBERT J. MRAZEK, New York
RICHARD J. DURBIN, Illinois
RONALD D. COLEMAN, Texas

SILVIO O. CONTE, Massachusetts
JOSEPH M. McDADE, Pennsylvania
JOHN T. MYERS, Indiana
CLARENCE E. MILLER, Ohio
LAWRENCE COUGHLIN, Pennsylvania
C. W. BILL YOUNG, Florida
JACK F. KEMP, New York
RALPH REGULA, Ohio
GEORGE M. O'BRIEN, Illinois
VIRGINIA SMITH, Nebraska
ELDON RUDD, Arizona
CARL D. PURSELL, Michigan
MICKEY EDWARDS, Oklahoma
BOB LIVINGSTON, Louisiana
BILL GREEN, New York
TOM LOEFFLER, Texas
JERRY LEWIS, California
JOHN EDWARD PORTER, Illinois
HAROLD ROGERS, Kentucky
JOE SKEEN, New Mexico
FRANK R. WOLF, Virginia
BILL LOWERY, California

FREDERICK G. MOHRMAN, *Clerk and Staff Director*

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

DEPARTMENT OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES APPROPRIATIONS FOR 1987

THURSDAY, MARCH 6, 1986.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH RESOURCES AND SERVICE ADMINISTRATION

WITNESSES

JOHN L. KELSO, ACTING ADMINISTRATOR

EDWARD D. MARTIN, MD, ACTING DEPUTY ADMINISTRATOR

JAMES A. WALSH, ASSOCIATE ADMINISTRATOR FOR OPERATIONS AND MANAGEMENT

VINCE L. HUTCHINS, MD, ACTING DIRECTOR, BUREAU OF HEALTH CARE DELIVERY AND ASSISTANCE

THOMAS D. HATCH, DIRECTOR, BUREAU OF HEALTH PROFESSIONS

DANIEL F. WHITESIDE, DDS, DIRECTOR, BUREAU OF HEALTH MAINTENANCE ORGANIZATIONS AND RESOURCE DEVELOPMENT

DENNIS P. WILLIAMS, ACTING DEPUTY ASSISTANT SECRETARY, BUDGET, DHHS

OPENING STATEMENT

Mr. NATCHER. At this time, we will take up the budget request for the Fiscal Year 1987 for the Health Resource and Services Administration.

We have before the Committee, Mr. John H. Kelso, the Acting Administrator. It is a pleasure to have you back before the Committee, along with the other gentlemen.

We will be pleased to hear from you at this time.

Mr. KELSO. Fine. I have a statement which I would like to introduce for the record.

[The statement follows:]

STATEMENT OF THE ADMINISTRATOR OF THE HEALTH RESOURCES AND SERVICES ADMINISTRATION

Mr. Chairman and Members of the Committee:

I appreciate this opportunity to appear before you today to discuss the fiscal year 1987 budget request for the Health Resources and Services Administration. As you are aware, Mr. Chairman, this budget excludes the Indian Health Service, which is reviewed by the Subcommittee on the Department of the Interior and Related Agencies.

The Health Resources and Services appropriation consists of health services, health professions and nurse education, medical facilities and health maintenance organization programs. The Administration will soon propose legislation to extend those authorizations for which funding is requested in the fiscal year 1987 budget.

The fiscal year 1987 budget request for Health Resources and Services is $1,182,670,000 and 2,489 full-time equivalent (FTE) employees. Included in this request are funds for: block grants to States to provide health services to mothers and children, the poor, migrants, black lung victims and other needy Americans; to continue the health care programs of the National Health Service Corps; to operate the Gillis W. Long Hansen's Disease Center; to provide a Federal payment to Hawaii for treatment of persons with Hansen's disease; to continue monitoring the medical facilities and health maintenance organization loan portfolios; and to manage the Health Education Assistance Loan program.

Health Care Delivery and Assistance

In 1987, $478,000,000 is requested for the Maternal and Child Health Block Grant, the same amount as was appropriated in 1985 and a 4.3 percent increase over the funds available in 1986. These funds will provide consolidated grants to each of 57 States and insular areas to provide a broad range of health services, including preventive care, primary care and rehabilitative services to mothers and children. Funds are allocated on a pro-rata percentage system. In addition, funds are provided for special projects of regional and national significance.

The Primary Care Block Grant is proposed to be expanded in 1987 to include community health centers, black lung clinics, migrant health centers, and family planning activities. The 1987 budget request provides $565,100,000 for grant awards to 50 States, the District of Columbia and Puerto Rico, and assumes the enactment of proposed new legislation. By combining categorical programs into the Primary Care Block Grant, this proposal will enable States to direct resources to the areas of greatest need while continuing to provide: primary care services; health services for respiratory and pulmonary impairments in coal miners; health services to migrant and seasonal farmworkers and their families; and family planning services to populations in need.

The 1987 budget request of $46,996,000 for the National Health Service Corps will support a total field strength of 3,292 physicians and other health professionals, including 571 federally salaried assignees. In addition to Federally salaried field assignees, 2,721 providers will be fulfilling their scholarship obligations as private practitioners, about the same number as in 1986. Through ongoing reliance on private placement with non-Federal employers and the private practice option, this budget will support approximately the same total field strength while permitting a significant decrease in Federal funding. Under private placement assignments or the private practice option, a person may complete the service obligation -- incurred while receiving a National Health Service Corps scholarship -- through private practice in a health manpower shortage area. A private practice assignment requires no direct Federal salary support and thus provides needed service at less expense to the government.

In 1987, 990 scholarship obligors will be available for service for the first time. Of these, 50 are estimated to elect the private practice option and 727 will choose to serve in private placement settings. About 213 will become Federal employees -- 113 with the National Health Service Corps and 100 with the Indian Health Service.

The budget request includes $19,103,000 for the continuation of patient care, medical education and research activities at the Gillis W. Long Hansen's Disease Center, for Hansen's Disease contract patient care, and for payments to survivors and dependents of the Tuskegee Syphilis Study. Also requested is $750,000 for routine recurring repairs and improvements at the Gillis W. Long Hansen's Disease Center at Carville, Louisiana. Also requested is $2,500,000 for payments to the State of Hawaii to partially support the cost and treatment of persons with Hansen's disease; and $29,132,000 to manage and operate all programs of the Bureau of Health Care Delivery and Assistance. Beginning in 1986, total costs for the Federal Employee Occupational Health program, including consultation services, will be on a reimbursable basis. A total of 147 FTEs needed to carry out this function will be supported through the reimbursements. The total budget request for the Bureau's health service programs is $1,140,831,000 and 1,532 FTEs, excluding 147 reimbursable FTEs.

Health Professions

Federal efforts in support of health professions programs have provided a considerable investment during the last two decades in increasing the supply of health professionals (e.g., the number of physicians has increased by 197,700 or 61 percent since 1970; nurses have increased by 754,300 or 101 percent in the same period). They have contributed to improved specialty and geographic distribution of physicians, nurses, and other health professions, resulting in increased access and equity of services for rural and urban underserved populations. For example, there has been a decrease of 12 percent in the number of primary care health manpower shortage areas between June 1983 and December 1985 and a 25 percent decrease in the number of primary care physicians needed in these areas to bring them above the threshold for designation.

With the increasing supply of health professionals in the United States, the Federal government no longer needs to provide annual support. The Administration believes that the current and likely future supply of health professionals makes funding for health professions training programs a lesser budget priority. Federal support has built an infrastructure that should enable the institutions involved to continue these programs in the future.

In recognition of these trends, the Administration proposes discontinuation of health professions education subsidies in fiscal year 1987. The fiscal year 1987 request includes $3,401,000 and 72 FTEs for direct operations to administer the Health Education Assistance Loan program, the Student Loan Insurance Fund, the Health Professions and Nursing Student Loan revolving funds and for debt management and collection activities. The budget also requests authority to guarantee up to $100,000,000 in loans under the Health Education Assistance Loan program, which, combined with the cumulative Federal contributions to health professions and nursing student loan funds, will make $167 million available for student aid in 1987.

Proposed bill language to extend part of the Health Education Assistance Loan risk to lenders and to require borrowers to purchase credit life insurance, in concert with an increase in the loan insurance fee up to 8 percent, will assist in reducing the future potential drawdown on the Student Loan Insurance Fund resulting from increased defaults.

Health Maintenance Organizations and Resources Development

The budget request for the Health Maintenance Organizations and Resources Development for fiscal year 1987 is $15,628,000 and 243 FTEs. Some $10,000,000 of this amount will be obtained by the assessment of user fees for the qualification review process for Health Maintenance Organizations (HMOs), eligibility determinations of Competitive Medical Plans for the HCFA and to recipients of Hill-Burton loans and guarantees requesting modifications to existing loan agreements. No funds are requested for Health Planning programs, consistent with the Administration's long standing objection to the provision of Federal financial support for State and local health planning activities.

Direct operations funds will be used to: evaluate HMOs to determine whether they meet all requirements for Federal qualification; evaluate competitive medical plans to determine their eligibility to contract with the Health Care Financing Administration to provide care for Medicare beneficiaries; monitor qualified HMOs, including those with Federal loans and loan guarantees, to assure continued compliance with all Federal regulatory requirements; monitor approximately $1.0 billion in outstanding health facility loans and loan guarantees in order to minimize Federal default liability; ensuring that facilities which previously received Federal funding comply with requirements to provide a reasonable level of uncompensated care to persons unable to pay, estimated at about $500 million annually.

In addition, $20,000,000 is requested for the Medical Facilities Loan and Loan Guarantee Fund. The $20,000,000 requested in new budget authority, along with approximately $6 million in prior year unobligated funds and repayments of principal and interest, will be used to meet the total interest subsidy requirements of $26,000,000 in FY 1987.

Thank you for providing me with the opportunity to summarize the Health Resources and Services Administration budget for 1987.

Mr. Chairman and members of the Committee, my associates and I will be pleased to answer any questions you may have on the specifics of this budget request.

BIOGRAPHICAL SKETCH

NAME : John H. Kelso

BIRTHPLACE : Iowa City, Iowa

DATE OF BIRTH: June 16, 1925

EDUCATION : State University of Iowa, B.A. 1949
State University of Iowa, M.A. 1950

PROFESSIONAL ACTIVITIES

1. September 1982 - Present*
Deputy Administrator
Health Resources and Services Administration
Public Health Service, Department of Health and Human Services

   *Serving as Acting Administrator, Health Resources and Services Administration, since June 29, 1985.

2. January 1981 - September 1982
Acting Administrator
Health Services Administration, Public Health Service, Department of Health and Human Services

3. 1976-1982
Deputy Administrator, Health Services Administration, Public Health Service, Department of Health and Human Services

4. 1973-1976
Director, Office of Regional Operations
Office of the Assistant Secretary for Health
Department of Health, Education and Welfare

5. 1971-1973
Associate Administrator for Management
Health Services and Mental Health Administration,
Department of Health, Education and Welfare

6. 1968-1971
Assistant Administrator for Management, Health Services and Mental Health Administration, Department of Health, Education and Welfare

7. 1966-1968
Executive Officer, Public Health Service, Department of Health, Education and Welfare

8. 1962-1966
Assistant Executive Officer
Bureau of State Services/Environmental Health, Public Health Service, Department of Health, Education and Welfare

9. 1960-1962
Chief, Management Advisory Branch, Bureau of State Services/Environmental Health, Public Health Service, Department of Health, Education and Welfare

10. 1957-1960
Management Analyst, Public Health Service, Department of Health, Education and Welfare

11. 1955-1957
Management Analyst, Department of Agriculture

12. 1951-1955
Occupational Research Analyst, Department of the Navy

AWARDS

DHEW Superior Service Award - 1969
DHEW Distinguished Service Award - 1972
Senior Executive Service Bonus - 1980, 1981
Presidential Rank Award - 1982
Senior Executive Service Bonus - 1983, 1984, 1985

Mr. KELSO. I will try to summarize this very quickly. I think the budget which is before you has two characteristics. It is similar to the budget for the last two or three years. It also reflects a set of very difficult choices that had to be made among competing and very good programs given the fiscal restraints under which we are operating, so it does represent some choices based on budget priorities.

In addition to that, it proposes a primary health care block.

We will be glad to take questions.

Mr. NATCHER. Thank you, Mr. Kelso.

EFFECTS OF GRAMM-RUDMAN-HOLLINGS CUTS

Mr. Kelso, as you know, Gramm-Rudman-Hollings reduces Fiscal Year 1986 funding for your agency by $49,713,000. Would you tell the Committee what affect these cuts will have on the programs administered by the Health Resources and Services Administration?

Mr. KELSO. Two of our programs only received a 1 percent cut, Community Health Centers, and Migrant Health Centers. We believe that under Gramm-Rudman-Hollings we can operate our programs through 1986 at about the current service level. The only difficulty we might have is that we might not be able to expand some of the programs as we would normally have done.

Mr. NATCHER. The Department's report to the Committee on sequestration indicates that Gramm-Rudman-Hollings will eliminate 10 community health centers and will also eliminate 34 maternal and child health projects. The health center reduction alone is reported to cause 50,000 individuals to lose health services. In your view are any of these reductions serious enough to warrant a supplemental appropriation to restore funding to the original 1986 level?

Mr. KELSO. No, sir, Mr. Chairman. As I indicated, it is mostly expansion and we would not be pursuing a supplemental because we believe that we can maintain current services.

Mr. NATCHER. What will the impact of Gramm-Rudman-Hollings be on Federal staffing and management activities at your agency?

Mr. KELSO. The Agency, for the last five or six months, has had a rather restrictive employment policy. We believe we can get through 1986 without RIF's, without furlough, but we will be under restrictive hiring practices.

FY 1986 PROPOSED RESCISSION

Mr. NATCHER. The President's budget also includes rescission proposals totaling $211,455,000. $172 million of this amount relates to your original 1986 request to terminate Federal support for health professions and health planning. These are issues which Congress felt were resolved for 1986 when the President signed our appropriation in December. Do you have any new information to present to this Committee on these issues as justification for the rescission?

Mr. KELSO. I do not have any new information except that it is the continued policy of the Administration that under times of fiscal restraint, these programs should be reduced.

COMMUNITY HEALTH CENTER PROPOSED RESCISSION

Mr. **Natcher**. $21 million is proposed to be rescinded from the community health center program. We are told this rescission would cause the elimination of 30 centers and the loss of services to 200,000 persons.

Tell us where you expect these people to get medical care and why you believe the rescission is justified?

Mr. **Kelso**. I may have Dr. Martin respond.

Mr. **Natcher**. Please do.

Dr. **Martin**. I think that it is important to point out that the reductions in Community Health Centers were consistent with the reduction for all of the programs throughout the Agency that were requested for rescission.

It is anticipated that with regard to the Community Health Center reduction, alternatives not depending upon Federal support would have to be found in those communities.

Mr. **Natcher**. Dr. Martin, do you believe that those services would be available to the people?

Do the communities have resources to take care of these matters?

Dr. **Martin**. It is an example of difficult choices in times of fiscal restraint. It would be a matter of assessment. It is consistent with the basic charge of reducing all Congressional increases that were added on to the President's additional request.

Mr. **Natcher**. Dr. Martin, would this close any of the existing centers now in operation?

Dr. **Martin**. I think the income statement that was forwarded anticipated some would have to be closed and in others, there would be significant reductions.

Mr. **Natcher**. Do you have any idea of the numbers that would have to close and where they are located?

Dr. **Martin**. No, at this time, we do not have that information with regard to the specific locations. The anticipation is that there would be somewhere between 25 to 30 centers closed or that there would be a comparable reduction in services over a much larger number of centers.

Mr. **Natcher**. When you get the transcript, please give us the details. We want this information so that we can have it in the markup.

I want a right detailed statement in the record now in regard to the matter.

Mr. **Kelso**. I will be glad to do that.

[The information follows:]

Proposed Reductions in Community Health Centers

The budget justification indicates that under the revised 1986 level of $375 million for Community Health Centers that 550 centers will receive support. This would represent a reduction of approximately 40 from the number of centers supported in FY 1985.

At the present time it is impossible to predict exactly which centers would not receive continued Federal support. As in the past, the Health Resources and Services Administration will review each grant application against prescribed funding criteria to determine which centers remain a priority for receipt of limited Federal resources.

This year's reviews of Community and Migrant Health Centers (CHC/MHC) will emphasize governance, clinical and financial/administrative expectations as set out below:

Governance (42 CFR 51c.304 and 56.304).—Each governing board must represent the population of the catchment areas, with center users comprising a majority of membership of the board. Governing boards are expected to be responsive to the communities that they serve, fulfilling all of the functions and responsibilities specified in the legislation and implementing regulations.

Clinical (42 CFR 51c.102(c)(1)(i), 51c.303(a) and (p), 56.303(a) and (p), 56.603(a) and (n), 56.102(g)(1)(i)).—CHCs and MH Centers and programs must provide health services so that such services are available and accessible promptly, as appropriate, and in a manner which will assure continuity of service to the residents of the center's catchment area. Primary health services must be provided for all residents of the catchment area; such services include, but are not limited to, the diagnostic, treatment, and other services rendered by physicians and physician's extenders, perinatal services, and other preventive health services. In addition, a center must provide sufficient staff, qualified by training and experience, to carry out the activities of the center. In considering which projects to fund, the Secretary will consider whether a center has an appropriate number of full-time providers on staff who provide after hours coverage, have admitting privileges and hospitalize their patients.

Financial/Administrative (42 CFR 51c.303(g), 56.303(r) and (s), and 56.305(a)(3)).—CHCs and MH Centers and programs must seek to develop and utilize to the greatest extent possible other Federal, State and local, and private resources, and must seek to maximize non-grant revenues. In considering with projects to fund, the Secretary will consider applicant's plans to secure maximum self-sufficiency applicant's plans to secure maximum self-sufficiency and minimize dependence upon and need for subsequent CHC and MH grants.

ORGAN TRANSPLANT

Mr. NATCHER. The President's budget also proposes to rescind $2,471,000 of funds appropriated to initiate activities under the Organ Transplant Act of 1984. This would allow the "network" to be funded but would not fund the new grants program. Would you explain why you are opposed to an organ procurement grant program?

Mr. KELSO. The organ procurement organizations are increasing in the private sector. The medicare programs fund kidney transplants, so the Federal government is already involved in supporting those activities. Our budget request reflects the difficulties of tight budget priorities.

Mr. NATCHER. How will the $400,000 for the Organ Procurement Network be spent in 1986? is this a one time cost or will additional funds be required in later years?

Mr. KELSO. It is a one time cost in Fiscal Year 1986. We expect to award a contract in June of this year for the network. It really involves creating data elements which will better permit the program to track the acquisition and disposition of organs. In addition, we hope to have the network be self-sufficient through user fees or other third party reimbursements.

NATIONAL HEALTH SERVICE CORPS

Mr. NATCHER. In addition to your community health center rescissions, you are also proposing a rescission for the National Health Service Corps of $2,445,000.

If both of these were accepted, would you still be able to place all Corps scholarship obligors in 1986?

Dr. MARTIN. If both rescissions were accepted, it would be necessary to place an estimated 450 of the National Health Service

Corps' assignees who were anticipated to be placed as employees of health centers as Federal employees instead.

It would require the submission of a supplemental for the full year costs of those Federal assignees in Fiscal Year 1987.

GRAMM-RUDMAN-HOLLINGS REDUCTIONS

Mr. NATCHER. Mr. Pursell, I will yield to you.

Mr. PURSELL. Thank you, Mr. Chairman.

I am pleased to see you before the Committee again, Mr. Kelso. I was not exactly clear to what you were referring when you said that a couple of your major programs only received a 1 percent reduction and the rest were consistent with the other agencies.

Will you tell us a little about that?

Mr. KELSO. That is a part of the law. Some health programs did not receive the 4.3 percent reduction. In our Agency it was community health centers, migrant health and the Indian Health Service which is not heard before this Committee.

Mr. PURSELL. Those three were the only ones?

Mr. KELSO. There were others, but those are the three in our Agency.

Mr. PURSELL. Those three were the only ones relevant to your Agency?

Mr. KELSO. Yes.

Mr. PURSELL. So you had no flexibility whatsoever?

Mr. KELSO. In the programs that are before you, two of the programs were 1 percent. The rest were the normal 4.3 percent.

Mr. PURSELL. Have you anticipated the "worst case scenario" for the fall?

Have you any anticipation of that or planning for that eventuality?

Mr. KELSO. Yes, we have.

Mr. PURSELL. What are some of your insights as to that?

Mr. KELSO. Well, we are also confronted with the fact that this budget proposes to eliminate the Health Planning Program and the Health Professions Program.

So, given that plus the Gramm-Rudman-Hollings Act in 1987, we would be in a reduction in force situation in fiscal 1987.

Mr. PURSELL. What would be the maximum number you would have to lose?

Mr. KELSO. I would have to enter that for the record.

Mr. PURSELL. Would we call that a "worst case scenario," anticipating that Congress may not have a final alternative?

We do not have at this point any recommendation from you as to what the impact would be?

Just sit back and take the consequences?

Mr. KELSO. The President's budget that we are defending here outlines the program proposals and we are operating on the premise that these will be adopted.

[The information follows:]

REDUCTION IN HEALTH RESOURCES AND SERVICES (HRSA) EMPLOYMENT

The FY 1987 President's budget request would result in a reduction-in-force of 727 full-time equivalents from the FY 1986 revised estimate for the direct operations activities in HRSA.

CENTER FOR NURSING RESEARCH

Mr. **Pursell**. In response to the mandate of Congress, we would develop a nursing center at NIH.

Can you tell us more specifics about that?

Mr. **Kelso**. It will be at the National Institutes of Health. The NIH has developed an implementation plan to establish that center.

Mr. **Pursell**. Has it been made public as well?

Mr. **Kelso**. No. I am not developing it. NIH is developing it, but I can ask the PHS to supply that.

In the interim, we are administering the program until it is established.

Mr. **Pursell**. What is the effective date of transfer, is it the beginning of the Fiscal Year?

Mr. **Kelso**. It would be somewhere in the late spring or summer, somewhere in 1986.

Mr. **Pursell**. Will any of the personnel be transferred?

Mr. **Kelso**. Approximately 8 people.

Mr. **Pursell**. How many full-time employees do you have in nursing research?.

Mr. **Kelso**. That is the 8 people.

Mr. **Pursell**. All will be transferred to the NIH Center?

Mr. **Kelso**. Yes.

NURSING SUPPLY

Mr. **Pursell**. We had this under Califano, that we had a nursing shortage. Some of the people in this Administration claim there is no shortage. There may be a lot of nurses who have certified professional degrees, but in the field you see hospitals and nursing centers in the ads that are looking to fill full-time nursing positions today. There was a report just recently. In 1983, we had the Institute of Medicine report which concluded that nurses of high quality with graduate education are scarce.

However, the Administration contends that there is an adequate supply of nurses.

Would you care to comment on your information as to the current reports along that line?

Mr. **Kelso**. That is a very complex area. I would prefer to have Mr. Hatch respond to it.

Mr. **Hatch**. Our projection for the future supply of staff nurses, is that they will be approximately in balance over the next several years up to the year 2000. There does seem to be a distribution problem among the nurses, with doctoral training, master degree training and bachelor degree training. There may not be enough at those levels, but the number of bachelor nursing programs has increased significantly over the past 10 years, and they are continuing to increase.

One of the things that makes it even more complicated is that it appears to be developing and we do not have any very detailed information on it. It appears that the application of DRG's is causing different reactions by the hospitals. Some are concentrating on employment of LPN's and nurses aides. Others are going to a registered nurse staff. A lot is happening.

We expect that the overall supply will be in balance by the year 2000.

Mr. **Pursell**. An Institute of Medicine study was published in 1983. Are you familiar with it?

Mr. **Hatch**. Yes.

Mr. **Pursell**. Recommendation number 8 is that the government should expand its support to increasing the rate of the growth in the number of nurses with masters and doctoral degrees.

I guess you are suggesting that maybe there are some areas you need to strengthen, particularly in the advancement program.

In light of the scenario which may consolidate what I have always considered a fragmented program in health in terms of line items, we are putting this under an umbrella. This center may help fine tune some of the needs of the country with respect to that.

I would be hopeful that you could be helpful.

Mr. **Hatch**. The programs transferred to the National Institutes of Health would be those for training nurse researchers and for the support of research projects. The advanced educational training and nurse traineeships program would stay in our Agency and be administered as they are now.

Mr. **Pursell**. I know it is not complete. It seems that the nursing field does not have a lot of personnel in policymaking positions. I look at your table and I see no nurse is present. It strikes me as being a little bit out-of-balance in terms of affirmative action programs these days. We generally have not had nurses in high policy roles to develop that kind of national commitment for research, advanced training, and the development of good policy in that field which is critical in the health field.

So, why is that?

Mr. **Hatch**. The Director of Nursing, Ms. Elliott, is a key member of our organization. She is active in working with us and across-the-board in the health professional area.

Up until recently, there was a nurse in charge of the Health Care Financing Administration. She was very instrumental in reforms which have taken place.

Mr. **Pursell**. She came from my university, the University of Michigan.

When you look at the Surgeon General's record, there has not been a good record of nurses developing public policy. Every year, there are lots of vacancies and some that are still available at high policy levels in the health field.

Mr. **Kelso**. The Deputy Surgeon General is a nurse, Dr. Abdellah.

Mr. **Pursell**. It is a great record for a nation of this size. I hope the Center eventually further strengthens the already strong professional community. I think it is a fragmented health policy from top to bottom. I hope that we are making some progress, as small as it may be.

Any comment on that?

Mr. **Hatch**. No, sir.

Mr. **Pursell**. Thank you, Mr. Chairman.

Mr. **Natcher**. Mr. Early.

HEMOPHILIA PROJECTS

Mr. **Early**. Thank you, Mr. Chairman.

The justification indicates that funds for hemophilia projects will decrease by $200,000 between 1985, and 1986; yet the number of projects are projected to increase from 24 to 25 between 1985 to 1986.

In 1987, you are planning to support 26 projects with the same amount of funds that supported 24 projects in 1985.

First of all, is that true?

And how do you propose to accomplish this?

Mr. **Kelso**. Dr. Hutchins may respond.

Dr. **Hutchins**. The program has been moving to a regionalized program with satellites and 10 centers. So within the funds available, we plan on doing what is outlined there.

Mr. **Early**. I am not sure it is. There is nothing more disturbing than when you see kids with AIDS, and a 12 year old that does not have his peers accepting him.

Dr. **Hutchins**. We have been working in two areas. One is to keep up and to make information available to the providers and parents and also providing a cyclesocial support to the providers and parents of these hemophiliac patients, who have great concerns about AIDS.

Mr. **Early**. But when you talk about that psychosocial support, there were five specific efforts we were going to support. There was a hemophilia information exchange, a program to address patient-family stress, a program on the use of the plasma, a voluntary program, and so forth.

You tell us that you will reduce the budget $200,000. You are not going to be able to do the things as well.

Dr. **Hutchins**. With the funds available under Gramm-Rudman-Hollings, we hope to do as much as possible.

Mr. **Early**. You are telling us we will do less. It will be a political savings.

What are we doing in the hemophilia centers program with regard to recommendations from the working groups? Are we cutting back in each one because of the money?

Dr. **Hutchins**. No, the information exchange is continuing. The voluntary data collection is continuing. We are working with the Centers For Disease Control to distribute some monies to the centers that came in the Centers For Disease Control appropriation this year to support psycho-social services for providers and families.

Mr. **Early**. But with the cutback in the expansion of the program, I do not know how you are going to do it. A 12 year old hemophiliac who has nothing to do with it, has AIDS, and cannot go to school. The other Americans are objecting. It is disturbing.

Bring us up to date with regard to AIDS and hemophilia.

Dr. **Hutchins**. Well, 90 percent have positive blood tests. It is estimated that 10 percent with a positive blood test so far will develop AIDS. We are not clear about that. There was hope last year that after another year we would have passed the 7 or 6 years that seems to be the risk factor.

There is evidence that shows the risk may go on later.

As of January, they found 150 AIDS patients dead.

Mr. Early. Is the number of hemophiliacs with AIDS on the rise or decline?

Dr. Hutchins. It is the same. Since the blood product has been changed in how it is prepared, there are no new hemophiliac patients who are testing positive for AIDS.

LOAN DELINQUENCIES AND DEFAULTS

Mr. Early. What progress has been made in reducing the number of delinquencies and defaults in loans?

Mr. Kelso. In the National Health Service Corps Scholarship program, the default rate has been going down. It is about 16 percent. There are approximately 1,500 people in delinquent status. Of that 1,500, 500 did not complete their training, so really could not be placed.

Mr. Early. Are you going to use the Internal Revenue Service? I have no objection to using it.

Mr. Kelso. The regulations to do this are under development, but we have been very strict on defaults and we have been very strict on waivers.

It is a very disciplined program.

On the health profession student loans, I think I will let Mr. Hatch come up with those numbers.

Mr. Hatch. We have been successful in bringing the health profession students' loans to an acceptable level of deliquencies.

Mr. Early. There should be no number acceptable.

Mr. Hatch. I agree. The health professions schools have been able to bring it below 5 percent, which is quite good.

We applied the performance standards to these schools beginning last summer, and as of the end of this past year, there are only 15 health professional schools out of the 330 that participate in that program that are above the required performance standards.

In the nursing student loan program, the deliquencies are running at 18 percent. We will be applying the same standard as we are to the health professions program.

Mr. Early. I have more sympathy for the nurses. I have a youngster at home and it will cost $50,000 for her to go to college. How will a cop or a mechanic do that?

I agree with Mr. Pursell that we do not possibly save any money when we cutback on these programs.

Mr. Kelso. The health profession student loan program is not being cut back. The money is out there in revolving funds.

Mr. Early. Those two funds were refinancing themselves, the one that had $18 million and the one that had $49 million. If they allowed what this Committee did several years ago, that would have straightened itself out over the years.

Mr. Kelso. There is more money circulating through.

Mr. Early. How much is being requested in for HEAL?

It is a $289 million decrease. Correct me if these numbers are wrong. We will serve 39,292 borrowers in 1986. Your justification expects an increase of approximately 12,000 borrowers in FY 1986 and you have money in for only 10,000 borrowers in FY 1987.

Mr. **Kelso**. The reason for the $100 million ceiling is the concern on how many defaults we will have in the outyears. That is the rationale for the $100 million.

Mr. **Early**. Do you agree we run a program and let the violators decide how we run it?

Mr. **Kelso**. I am not saying that. We are concerned about the number of defaults in the outyears.

AREA HEALTH EDUCATION CENTERS

Mr. **Early**. There would not be any because there would not be any loans. If you reduce defaults to $100 million, you can come in and say the default rate is going down because you are not giving any new loans. Boy, some of that is not progress.

In what AHEC activities will the Gramm-Rudman-Hollings reduction be taken?

Mr. **Hatch**. Assuming the 1986 appropriation with the 4.3 precent reduction, Mr. Early, we might not fund as many new projects as we could otherwise.

All of the present AHEC program would be funded under Gramm-Rudman-Hollings at their current services.

Mr. **Early**. Do you have a 12.5 million rescission, after the sequestration?

Mr. **Hatch**. The sequestration level would only affect our ability to fund new projects this year.

Mr. **Early**. Mr. Kelso, you have a tough budget to do half of the things that you have done in the past.

Mr. **Natcher**. Mr. Conte.

Mr. **Conte**. Thank you, Mr. Chairman.

I want to join the Chairman in welcoming you here, Mr. Kelso. You have a distinguished record. Let me also welcome the rest of your team, Dr. Martin, Mr. Hatch who have been particularly helpful in the past. We can count on their expertise and advice in the coming year.

COMMUNITY HEALTH CENTERS

Mr. **Conte**. The Fiscal Year 1986 appropriations for Community Health Centers provided $400 million, an increase of $17.5 million over Fiscal Year 1985, later reduced to $396 million because of Gramm-Rudman-Hollings. The Conference Report indicated, that in distributing the increase, the Department was to balance the need for increased operating costs at existing centers, with the need for new services in high priority areas.

Your justification indicated that you will do so. Let me just ask it though.

Assuming the $21 million rescission request expires, you are planning to fund new services, in high priority areas; is that correct?

Mr. **Kelso**. If the $21 million rescission is not agreed to?

Mr. **Conte** Yes.

Dr. **Martin**. There is a plan for expansion in areas that presently underserved. We anticipate that there will be between 10 or 25, assuming that there is no rescission.

FACILITY CONSTRUCTION

Mr. CONTE. The Fiscal Year 1986 appropriation provides $5 million for Section 1610 of the Public Health Service Act, to fund construction or conversion of clinics and outpatient facilities. The Conference Report gives priority to building and equipping outpatient medical facilities which are located in rural or urban poverty areas; which are located in health services shortage areas; and have recently experienced a disruption due to a natural disaster such as a flood.

Assuming the rescission request for these funds is not approved, will you be putting out a request for proposals, or will you be accepting unsolicited applications, or how will you proceed?

Mr. KELSO. Dr. Whiteside.

Dr. WHITESIDE. Any facility which wishes to apply will be able to submit an application. We intend to put out an announcement in the Federal Register.

Mr. CONTE. Should they wait until the Federal Register comes out?

Mr. KELSO. Yes, sir.

Mr. CONTE. What if a community is interested in these funds; how should they be proceeding at this point?

Dr. WHITESIDE. They should wait for the Federal Register to come out.

HEALTH PROFESSIONS

Mr. CONTE. In the past few years, there has been a growing attention given to an expected surplus of most health professions disciplines by 1990. Of course, this is the reason given in your budget for zeroing out all the health professions training money. However, vocal that attention has been, the need still seems to exist for a number of specialists, including epidemiologists, environmental health professionals, public health nurses, nutritionists, and health educators ready to address the special problems of children, the aged, and the disadvantaged.

If you could look at this situation without all of our fiscal pressures, and I know that is hard to do, which of all these programs seem to make the least sense in terms of current surpluses, and which might still be deserving of our support?

Mr. KELSO. Can we supply that for the record?

Mr. CONTE. Yes.

[The information follows:]

HEALTH PROFESSIONS

In the aggregate, the national supply and requirements for the health professions including nursing are projected to be in rough balance in 1990 and 2000. We agree that needs continue in some special areas: primary care; preventive medicine; epidemiologists; environmental health professionals (including toxicologists); public health nurses; nurses with advanced education; and increased emphasis on improving the capabilities of health professions to care for the elderly. In addition, there will always be some geographic areas in the country that cannot support the necessary economic and professional settings essential to attracting and retaining physicians and other health professions. Minorities continue to be underrepresented in the health professions. Profound changes in the health care delivery system could alter supply-demand equation, but there is no quanitifiable evidence to date to document the impact of such changes; and thus, the need to monitor these changes continues.

SPECIAL EDUCATION INITIATIVES

Mr. Conte. Assuming the $8 million for health professions special education initiatives is not rescinded in Fiscal Year 1986, on what categories of initiatives do you plan to spend the funds, and approximately how much will you spend in each category?

Mr. Hatch. The total of $8 million in the 1986 appropriation is planned for use primarily for continuing support of geriatric education centers which are for the purpose of improving the capability of health professionals in dealing with the aging population. We also have a million dollars that would be paid for continuation of grants for improving the geographic distribution of podiatrists. This would be the third year of support for this program.

In addition then there was a special identification of an activity for developing computer simulation in arthroscopic surgery which was in the House report last year. That would be the remaining activity that would be carried out for those programs.

GERIATRIC CENTERS

Mr. Conte. Tell me more about the geriatric program.

Mr. Hatch. We have about 20 centers we are supporting around the country. The purpose is to establish them at health profession schools and/or at a consortia of schools to deal with geriatric patient needs. They carryout programs in faculty development and continuing education for currently practicing professionals. Each of these centers addresses itself to a particular geographic area in which they work with the various schools within the area.

Mr. Conte. You say there are 20?

Mr. Hatch. Yes, sir.

Mr. Conte. Will you please supply any other information you have in the field?

Mr. Hatch. I will be glad to.

[The information follows:]

Geriatric Education Centers (GEC)

A total of 20 GEC have been funded through FY 1985. Four were initially funded in FY 1983. Those four continued in FY 1984 and FY 1985, and 16 new centers were funded in FY 1985. Funds awarded to GECs totaled $871,734 in FY 1983, $957,972 in FY 1984, and $6,020,070 in FY 1985.

The purpose of these centers is to provide a comprehensive range of educational services within their target areas, to include intensive and extensive training opportunities in geriatrics/gerontology for faculty of health professions schools, multidisciplinary consultation and assistance concerning geriatric curricula, and other educational services such as continuing education and educational information referral systems. Organized under varying administrative arrangements, all of the centers have directors and staff with appointments in medical and other health professions schools.

The geographic distribution of GECs is extensive. Thirty-six States and Puerto Rico are served by these GECs and a wide variety of health professions are included. All 20 GECs involve the professions of medicine and nursing. Health professions involved in 50-85% of the 20 GECs are dentistry, pharmacy, social work, occupational therapy and physical therapy.

The pooling of resources in geriatrics education is emphasized. There are a total of approximately 155 participating institutions and organizations directly affiliated with the 20 GECs. The number of faculty trained by September 1986 will be 4,684.

Examples of training range from one-on-one clinical training of 6 months duration to attendance by short term continuing education seminars. Technical assistance and continuing education efforts are wide-spread. The consultation, technical assistance and continuing education efforts of the GECs are estimated to ultimately impact on approximately 90,000 practitioners in 1986.

FINANCIAL DISTRESS

Mr. CONTE. Under the reauthorization for health professions passed by the House earlier this year, we approved a time-limited extension for the four schools receiving assistance under the Financial Distress Program. Can you tell us what the timetable for these schools is in that reauthorization?

Mr. HATCH. According to the current schedule Fiscal Year 1987 would be the sixth and final year of support under the advanced financial distress program.

We had already funded the amounts due in Fiscal Year 1986 projects and all of 1986 has been taken care of.

The authorization for 1987 would require just under $3 million for the advanced financial distress projects.

HEALTH PLANNING.

Mr. CONTE. On January 22, I wrote to Dr. Whiteside on the Health Planning Program.

Do you remember that?

Dr. WHITESIDE. Yes, sir.

Mr. CONTE. Given the appropriation of only $28 million to keep the agencies funded only through the end of September, pending reauthorization, which could cause some HSA's severe fiscal problems even prior to that time, and our clear statement that it was our intention that the HSA's remain up and operating over this time time frame, I asked about the possibility of moving up the date of the payment of matching grants. Usually they are paid in September, but there is no reason why they could not be paid earlier, and I am aware that the HSA in my district could really use the funds in April. Your response of February 6th indicated that you have been examining the legal and administrative feasibility of distributing these funds on a different time schedule.

What has your examination concluded, and how can we get these matching funds out sooner to HSA's that are struggling to stay in existence through the end of the Fiscal Year?

Dr. WHITESIDE. We will be able to move the dates of the distribution of the matching funds up to the early part of the fourth quarter. That statement is based on the assumption that the rescission that we have proposed of $16.5 million for the health planning is not accepted. If the rescission is accepted there will be no money for matching purposes.

INFANT MORTALITY

Mr. CONTE. We will try to help you there.

What are your thoughts on why the decline in infant mortality rates is slowing so dramatically?

Mr. KELSO. Infant mortality is a very complex subject. The overall rate is declining; however the decline is not as fast as it has been in the past. Within HRSA we have the Maternal and Child Health Block Grants. You will notice in the budget before you we are asking for full funding up to the authorization of $478 million. High priority is given to infant mortality.

The world's greatest expert on that is Dr. Hutchins.

I will ask him to elaborate a little bit.

Dr. HUTCHINS. Mr. Kelso summarized it quite well. The rate of decline has slowed in the '80's as compared to the '70's.

It is a complex problem. We are not sure of all the reasons for it. We are looking at it carefully.

One of the factors is low birth weight. That figure stayed constant. The low birth weight children live because of the care given to infants.

Mr. CONTE. That is encouraging.

Thank you kindly, Mr. Chairman.

Mr. NATCHER. Mr. Porter?

PROPOSED EXPANDED PRIMARY CARE BLOCK GRANT

Mr. PORTER. Mr. Kelso, for how many years has the Administration been working on this being proposed?

Mr. KELSO. Five years.

Mr. PORTER. Why do you keep proposing it because Congress does not feel inclined to do it?

Mr. KELSO. The Administration feels that the programs proposed to go into the block grant would be more helpful to the States if put in a block grant approach.

The States would set the priorities.

Mr. PORTER. Have you made any surveys as to what would happen to some of the programs if the States would take over them?

Mr. KELSO. No, but in the last five years the Community Health Centers have worked very closely with the States. They are deeply involved in deliberations even in the categorical program that we now have. We have no reason to believe that the States would not do very well.

HEALTH PLANNING

Mr. PORTER. Let me ask you about health planning. I think that we agree that this is a program that we do not need and it has not actually done much good. I think it is finished as of October, is it not?

Mr. KELSO. The Health Planning Program was not legislatively authorized but it was authorized by this Committee through appropriations. It is scheduled for termination by the end of this fiscal year.

HEALTH MAINTENANCE ORGANIZATIONS

Mr. PORTER. We will make sure that it is terminated.

How about HMO's?

Are they expanding?

What is your projection ahead?

Mr. **Kelso**. The HMO program movement has caught on and it is expanding. It has become a full feature in the health care delivery system, but let Dr. Whiteside expand on this.

Dr. **Whiteside**. It is expanding rapidly. Enrollments are increasing dramatically. I would be happy to provide you with some statistics that show that.

Mr. **Porter**. Is this expansion even?

Dr. **Whiteside**. Some areas are using them more than others but they are developing rapidly all across the country.

[The information follows:]

STATISTICS IN HEALTH MAINTENANCE ORGANIZATIONS (HMO) EXPANSION

The number of prepaid health plans, including federally qualified HMOs, has increased from 123 in 1973 to 454 as of June 1985 with enrollments up from 5 million to over 18.9 million. In the period from June 1984 to June 1985 the total number of prepaid plans including federally qualified HMOs increased from 337 to 454 with an enrollment increase of approximately 3.8 million. During FY 1985 we qualified 95 HMOs and this exceeds the total qualified during FY 1982 to FY 1984 combined. We expect this increased application trend to continue.

During the past two years more than $540 million in equity and debt financing has been made available to the HMO industry where no public market existed previously. Estimated industry revenues for 1986 are $18.5 billion.

Mr. **Porter**. My understanding is that geographical differences occur or rather cost differences by geographical regions are taken into account in negotiating these contracts; is that so?

Dr. **Whiteside**. That is my understanding.

Mr. **Porter**. Is there any specific revision that affects the philosophy of any single rate as we are applying it to DRG's?

Dr. **Whiteside**. As I understand, the DRG as it is currently being done, is partially adaptable to differences in cost across the country.

Mr. **Porter**. The law says it would move to a national rate. It has been put on hold.

Is there any similar provision that moves HMO's in that direction?

Dr. **Whiteside**. Not to my knowledge; no.

FAMILY PLANNING

Mr. **Porter**. I am glad to hear it.

The Secretary testified yesterday before our Committee about his own feelings about family planning. We did not discuss the question of abortion, but we had discussed that question with the Secretary Heckler when she testified before our Committee in 1984 and 1985. It was her opinion through HHS auditors and GAO that Title X family planning clinics are not using Federal funds for abortion. Is that your finding also?

Mr. **Kelso**. The family planning program is in our budget but is administered by the Office of the Assistant Secretary for Health. I would have to defer to them on that question.

Mr. **Porter**. I do not have any other questions, Mr. Chairman.

FAMILY MEDICINE AND INTERNAL MEDICINE

Mr. **Natcher**. Now, Mr. Kelso, the Department's May 1984 "Report to the Congress on Health Personnel" indicates that, and I quote "many areas continue to remain short of certain types of public health professions, particularly primary care physicians."

Your budget, however, proposes to terminate the family medicine and internal medicine programs. These are the government's principal programs to train primary care physicians.

Is it not true that there continues to be shortages in these two specialities in many areas of this country, such as the state of Kentucky?

What about this, Mr. Kelso? We know you did not do this. That must have been somewhere up the line. Talk to us about it.

Mr. KELSO. These programs have been funded over the past 10 or 15 years. They have been very successful and have produced an adequate supply of health professionals.

They have built an infrastructure and capacity out there for the production of health professionals, but given the competition for the dollar in the Federal budget, these programs are not being proposed for funding. It is a matter of fiscal restraint.

Mr. NATCHER. Mr. Kelso, yesterday, the new Secretary testified before our Committee. He said, not particularly refering to this program, that programs concerning family medicine training should be expanded.

That was my recollection about what he said. I agreed with him. I thought that he was right. He made a good impression on this Committee, the new Secretary did, and I hope that he continues because I believe that he will be a good Secretary.

Mr. Kelso, when you get the transcript, go into a little more detail on this particular matter.

Mr. KELSO. I will be very glad to.

[The information follows:]

HEALTH PERSONNEL

The *Fifth Report to the President and Congress on the Status of Health Personnel in the United States*, sent to the Congress on March 3, 1986, continues to note the ongoing decline in the percentages of general/family practitioners among all MDs, from 12.8% in 1980 to 12.3% in 1983. This decline, coupled with the moderated growth in internal medicine and pediatrics, has produced a relatively constant rate of growth in the primary care specialties, not only since 1980, but throughout the 1970's when Federal support for family medicine was its strongest. Data continue to indicate that family physicians are cost effective and distribute themselves in proportion to the general population.

DISADVANTAGED ASSISTANCE

Mr. NATCHER. Your May 1984 report also indicates that minorities continue to be underrepresented in the health professions. Your justifications describe the disadvantaged assistance program as "the principal federal programs aimed at increasing the numbers of minorities that go into these professions." The budget eliminates the program altogether.

Tell us why you are opposed to the disadvantaged assistance program?

Mr. KELSO. Here again, my answer has to be couched in terms of fiscal restraint and priorities for the Federal dollar. Relatively speaking, minorities in the health professions have increased in absolute numbers.

NURSING SUPPLY AND DEMAND

Mr. **Natcher.** One last question on the health professions. You propose to eliminate all support for nursing programs. As you know, however, the National Academy of Science two years ago strongly endorsed continued Federal support of Federal efforts in this field.

Secretary Bowen participated in the Academy's review of this issue.

Do you have any evidence to present to this Committee which would indicate that the supply and demand data developed by the Academy was then or is now in error?

Mr. **Kelso.** If I could supply that for the record, I would appreciate it.

If we have any, I would like to supply it for the record. The fiscal restraint comment I have given you would prevail.

Mr. **Natcher.** We always like to have you come before the Committee. When you leave this morning, we want you to know this.

[The information follows:]

Supply and Requirements for Registered Nurses

The National Academy of Sciences developed its conclusion from its own assumption on projected supply and requirements. These assumptions were applied to 1980 data available from the Health Resources and Services Administration (formerly Health Resources Adminstration).

Data from the recently released National Sample Survey of Registered Nurses indicate that there were an estimated 90,500 employed registered nurses with master's and doctoral degrees in November 1984. In the Fifth Report to Congress on Health Personnel, the supply and distribution of and the requirements for nursing personnel contain a projection of requirements for the year 2000 of 515,000 full-time equivalent master's and doctorally prepared registered nurses. These requirements are generated from a model which measures the number and levels of educational preparation of nursing personnel needed to meet a particular set of health care goals.

NURSING SUPPLY

Mr. **Natcher.** Do you have any evidence to submit to this Committee which would support a conclusion that the number of graduate nurses, nurse faculty, nurse midwives, or nurse practitioners is in excess of the need for these personnel?

Do you have anything? What about it, Mr. Walsh?

Mr. **Hatch.** No, I do not believe that there is any evidence that would indicate contrary information.

HEALTH PLANNING

Mr. **Natcher.** All right.

Last year, Congress approved a total of $28 million for the Health Planning Program based on the passage of legislation in the House which would sunset this program at the end of Fiscal Year 1986.

Describe for the Committee how you would handle closeout activities if the program is not reauthorized?

Mr. **Kelso.** We have been working with the HSA's. They are fully aware that this program is scheduled for termination at the end of the Fiscal Year. They are fully aware that this is coming.

Within the Agency, we would, at the beginning of Fiscal Year 1987 probably have to run a reduction in force for the people who are in the planning program.

Mr. **Natcher**. How many Federal employees are currently working on this planning program?

Mr. **Kelso**. I think it is 121.

Mr. **Natcher**. 121?

Mr. **Kelso**. Yes, sir.

Mr. **Early**. Mr. Conte.

MATERNAL AND CHILD HEALTH SET-ASIDE

Mr. **Conte**. Thank you, Joe.

I really hate to do this. I am going to have to slap you guys on the wrist a little bit.

Only through the grapevine did I find out that Massachusetts had been awarded two grants under the set-aside. I got no word about them from your agency. One of those projects, in part, will begin to help the City of Holyoke, in my district, where less than 50 percent of the pregnant women receive any kind of prenatal care.

If you have got the figures handy, can you give me an idea of how these projects will be affected by Gramm-Rudman-Hollings?

Dr. **Martin**. First of all, our apologies. The most important thing is to handle the political problem. We accept responsibility for the notification, or lack thereof. The bulk of the impact of the reduction as in other areas, will be in new projects under consideration and yet to be funded. There should not be a significant impact.

Mr. **Conte**. Staying on the issue of the set-aside for just a minute.

Mr. Kelso, as you know, the old genetics program was folded into the set-aside when we changed over to the block grant. We have been hearing a lot recently about new procedures for the early identification of genetic markers for diseases like sickle cell, Huntingtons, and cystic fibrosis.

Do the advances we are making in this area mean that we should be looking to increase the genetics program under M.C.H.?

Dr. **Martin**. Not only in genetic disease, but there continue to be a substantial number of technologic advances and changes. The real basis is to connect the technologic changes with providers and service systems. This would not require additional funding. We need to continue to adapt to how we fund the projects and what we focus on. A large part of our effort is in anticipation of the changes in ensuring that they become part of the care delivery system.

Technology in itself is anticipated and would require no additional increases to carry on the same type of program we are carrying out now.

AREA HEALTH EDUCATION CENTERS

Mr. **Conte**. I am glad that after the change Senator Kennedy and I got through in the reauthorization bill we finally resolved the problem of AHEC eligibility for special initiatives funding. Just one quick question for you.

Will you be using the full 10 percent set-aside for special initiatives projects in FY 1986?

Mr. **Hatch**. Yes.

NATIONAL HEALTH SERVICE CORPS SCHOLARSHIPS

Mr. **Conte**. Last year we talked some about the decline in new assignees under the National Health Service Corps Scholarships program.

What are your current estimates on the shrinkage in the pipeline of new assignees?

Dr. **Martin**. We can provide specifically for the record the exact numbers for the out years. We anticipate that FY '87 will be the last large year of placement, and 1988 and 1989 will begin to slow down. We can provide that precisely for the record.

[Information follows:]

The largest number of NHSC scholarship recipients available for service will be in Fiscal Year 1986 and will decline every year thereafter as follows:

1986	
1987	1,327
1988	990
1989	417
1990	176
1991	90
	45

NATIONAL HEALTH SERVICE CORPS

Mr. **Conte**. Another issue we talked about some last year would be development of departmental proposals to make changes in the program to ensure continuation into the 1990s.

Where are you at now with these proposals? Have they been developed?

Dr. **Martin**. The Administration supports the continuation of the National Health Service Corps program. There is a continuing effort to identify volunteers who, when established in practice, eventually go private.

We anticipate that the service aspect of the program can and will continue into the early and mid nineties essentially without substantial change.

NURSING SUPPLY

Mr. **Conte**. On nursing education in 1983, the Institute of Medicine report concluded that nurses with high quality graduate education are a scarce resource, and recommended an increase in the number of nurses with skills commensurate with "the growing complexity of care in many health settings."

From your justifications, I see that your contention is that the supply of registered nurses is adequate in this country. From what I am told, however, the nursing education monies are not targeted to increasing the number of general nurses; they are aimed at preparing nurses at the master's and doctoral levels, and that the demand still exists for nurses prepared at advanced levels, such as nurse midwives, nurse anesthetists, and clinical nurse specialists in geriatrics.

If that IOM report is accurate, why are you proposing to eliminate all the advanced nursing education programs?

Mr. HATCH. Individuals undertaking advanced nurse education have an earning capacity and during times of Federal fiscal constraints, can be expected to finance their further education and seek support from other Federal and non-Federal sources.

Mr. CONTE. Last year the Congress authorized, and this Subcommittee appropriated funds in fiscal year 1986 for new nursing demonstration projects to address concerns about access to nursing services.

Has the program been implemented yet?

Mr. HATCH. It was targeted for implementation this year. If there is no rescission, it will be implemented.

Mr. CONTE. So, if the rescission request is not approved, will you be prepared to move ahead in this fiscal year?

Dr. MARTIN. Yes.

Mr. CONTE. Does it seem strange to you that six months after the President signed a new three-year authorization for the Nurse Education Act, the budget comes up recommending complete elimination of the same nursing education programs?

Mr. KELSO. That goes back to what I was telling the Chairman. Throughout all the health professions programs, it is basically a feeling that they have been funded for 10 or 15 years, they have proved themselves and given the current fiscal climate, priorities had to be made. It is a fiscal restraint matter.

GERIATRIC TRAINING

Mr. CONTE. I always say this so it is getting to be a little old hat. My wife is a Navy nurse. She said you never turn your back to a nurse. Joe knows my wife. She is pretty tough.

We talked about geriatric training. Will that be reduced under Gramm-Rudman?

Mr. HATCH. By 4.3 percent, but we do not expect it will have any effect on the continuing programs. It might affect our ability to fund new projects this year.

Mr. Conte. If Congress does not approve your rescission request, how many projects will you be able to fund in FY 1986?

Mr. HATCH. About 20.

HEALTH EDUCATION ASSISTANCE LOANS (HEAL)

Mr. CONTE. Now, you are asking for appropriations language to raise the HEAL insurance premium to 8 percent.

What is the current premium, and how does it compare to those collected on other student loan programs?

Mr. HATCH. The appropriations language would not be required to raise the premium to 8 percent. That was authorized in the new law last fall. We plan, subject to the completion of an actuarial study this spring, to raise the premium to 8 percent beginning in July. The current premium is 2 percent, and to be honest with you, Mr. Conte, I do not know how that compares with other programs.

Our concern there is to establish a premium level that will be sufficient to maintain the viability of the insurance fund.

Mr. CONTE. What is the average debt burden of a medical school graduate, if you know?

Mr. HATCH. Approximately $30,000. It is higher in osteopathic medicine.

USER FEES

Mr. CONTE. Can you tell us about your user fee proposal for health maintenance organization, HMOs, and why you think this is something the Subcommittee should seriously consider?

Mr. KELSO. It is also in the Competitive Medical Plan [CMP]. People who apply for HMO certification or CMP certification, benefit from that certification, and we believe that the people who apply should reimburse the government for those efforts.

Mr. CONTE. What do you estimate you can collect?

Mr. KELSO. The budget proposes $10 million.

Mr. CONTE. Can you give us a breakdown on how much you estimate would be collected from HMOs, how much from charges for competitive medical plans, and how much from recipients of Hill-Burton loans?

Dr. WHITESIDE. The amount from Hill-Burton would be roughly $68,000. We would estimate perhaps as much as $7 million from the HMOs and maybe $3 million from CMPs.

UNCOMPENSATED CARE

Mr. CONTE. What is the current amount of uncompensated care monitored by the Bureau of HMOs and Resource Development under the Hill-Burton Act?

Dr. WHITESIDE. Five hundred million dollars of uncompensated care is delivered by about 4,600 facilities in the country, and we monitor them, as many of those as we can, each year.

TUSKEGEE SYPHILIS STUDY

Mr. CONTE. Can you tell us how many people are still receiving benefits as a result of the Tuskegee Syphilis Study in 1932?

Mr. KELSO. I do not have it at hand. I would be glad to enter it for the record.

[Information follows:]

According to information received from the Centers for Disease Control, which administers the Tuskegee Syphilis program, there are 113 people still receiving benefits from the program: 46 former participants of the study, 48 wives and widows, and 19 children.

GERIATRIC CENTERS

Mr. PURSELL. You were talking about the geriatric center. Can you tell me more?

Mr. HATCH. We began that program three years ago with the establishment of four geriatric centers, and with an increase in the appropriation in 1985, we funded 16 new centers.

The concept here is that we provide support to an institution or a group of institutions acting together for an improvement in materials and faculty trained in geriatrics for the schools in a particular geographic area. The geriatric projects support the bringing in of faculty from other schools to prepare them to teach when they go back home. The centers are supporting some curriculum development for geriatric education and some continuing education. They are multi-disciplinary centers rather than all focusing on a single discipline.

Medicine and nursing are involved in all of the centers and other disciplines participate as well. We think this program is a very interesting new development. It takes advantage of the particular capabilities of an institution that has been concentrating on this issue to provide expertise to other institutions in the geographic area that it serves.

Mr. PURSELL. Do they balance across the country?

Mr. HATCH. We are generally pleased. It is not as good a distribution as we would like in the mountain States, but they are spread across the country. We have 20 active centers now. Four will finish their commitment period this year.

The prospects of a competitive cycle this year are subject to the rescission. I will be pleased to submit the names of the geriatric centers for the record.

Mr. PURSELL. The funds go directly to the center?

Mr. HATCH. Yes, sir.

Mr. PURSELL. Historically, there have been a great many efforts made by several universities in our area.

Mr. HATCH. There are some very strong and interesting involvements. We want to take advantage of that where it exists and uses that expertise as the basis for improving these kinds of programs in other institutions.

Mr. PURSELL. Both private and public institutions?

Mr. HATCH. Yes, sir. Both are participating in it.

We were asked for additional information by Mr. Conte and will be submitting it for the record.

[The information follows:]

GERIATRIC EDUCATION CENTERS - FY 1985

SUMMARY TABLE

Name	Location	States Served	Type of Grantee Institution	Health Professions Served
Dakota Plains Geriatric Education Center	University of North Dakota Grank Forks, North Dakota	North Dakota and South Dakota	Public	Medicine, Nursing, Pharmacy, Physical Therapy, and Social Work
Delaware Valley Geriatric Education Center	University of Pennsylvania Philadelphia, Pennsylvania	Eastern Pennsylvania, Southern New Jersey, and Northern Delaware	Private	Dentistry, Medicine, Nursing, Optometry, Pharmacy, Physical Therapy, Podiatry, and Social Work
Geriatric Education Center at University of Alabama at Birmingham	University of Alabama at Birmingham Birmingham, Alabama	Alabama, Tennessee, and selected sites (Atlanta) in Georgia	Public	Dentistry, Dietetics, Medicine, Nursing, Occupational Therapy, Optometry, and Physical Therapy
Geriatric Education Center at Virginia Commonwealth University	Virginia Commonwealth University Richmond, Virginia	Virginia	Public	Clinical Psychology, Dentistry, Health Administration, Medicine, Nursing, Pharmacy, and Physical Therapy
Geriatric Education Center of Pennsylvania	Temple University Philadelphia, Pennsylvania	Pennsylvania	Private	Dentistry, Medicine, Nursing, Occupational Therapy, Pharmacy, and Physical Therapy
Geriatric Eduction Center of Puerto Rico	University of Puerto Rico San Juan, Puerto Rico	Puerto Rico	Public	Dentistry, Health Education, Medicine, Nursing, Nutrition, Pharmacy, Physical Therapy, and Social Work

(Continued on next page)

Harvard Geriatric Education Center	Harvard Medical School Boston, Massachusetts	Massachusetts, Rhode Island, Connecticut, Vermont, Maine, and New Hampshire	Private	Dentistry, Medicine, Nursing, and Social Work
Michigan Geriatric Education Center	University of Michigan Ann Arbor, Michigan	Michigan	Public	Clinical Psychology, Dentistry, Medicine, Nursing, Pharmacy, Public Health, and Social Work
Mississippi Geriatric Education Center	Univesity of Mississippi Jackson, Mississippi	Mississippi	Public	Clinical Psychology, Dentistry, Medicine, Nursing, Occupational Therapy, Pharmacy, Respiratory Therapy, and Social Work
Missouri Geriatric Education Center	University of Missouri Columbia, Missouri	Missouri	Public	Communication Disorders, Dentistry, Health Management, Medicine (allopathic and Osteopathic), Nursing, Occupational Therapy, Public Health, Physical Therapy, Respiratory Therapy, and Social Work
Mount Sinai-Hunter College Geriatric Education Center	Hunter College-Mount Sinai New York City, New York	New York City and Southern New York State	Public	Medicine, Nursing, Nutrition, and Social Work
Northwest Geriatric Education Center	University of Washington Seattle, Washington	Washington, Alaska, Montana, Idaho, and selected sites in Nevada and Oregon	Public	Dentistry, Medicine, Nursing, Pharmacy, Public Health, and Social Work
Ohio Valley/Appalachia Regional Geriatric Education Center	University of Kentucky Lexington, Kentucky	Kentucky, West Virginia, Northeastern Tennessee, Southern Ohio, and Indiana	Public	Dentistry, Medicine, Nursing, Occupational Therapy, Pharmacy, Physical Therapy, Physician Assistant, Respiratory Therapy, and Social Work

(Continued on next page)

Pacific Geriatric Education Center	University of Southern California Los Angeles, California	California, Nevada, Arizona, and Hawaii	Private	Dentistry, Health Services Administration, Medicine, Nursing, Occupational Therapy, Pharmacy, Physical Therapy, Physician Assistant, and Social Work/Gerontology
South Texas Geriatric Education Center	University of Texas Health Science Center at San Antonio San Antonio, Texas	South Texas	Public	Clinical Psychology, Dentistry, Medicine, Nursing, Occupational Therapy, Pharmacy, Physical Therapy, Public Health, and Social Work
Texas Consortium of Geriatric Education Centers	Baylor College of Medicine Houston, Texas	Texas	Private	Dental Hygiene, Dentistry, Health Care Administration, Health Education, Medical Sociology, Medicine, Nursing, Nutrition, Occupational Therapy, Optometry, Pharmacy, Physical Therapy, and Physician Assistant
University of North Carolina Geriatric Education Center	University of North Carolina Chapel Hill, North Carolina	North Carolina	Public	Dentistry, Medicine, Nursing, Pharmacy, Public Health, and Social Work
University of Utah Geriatric Education Center	University of Utah Salt Lake City, Utah	Utah and selected sites in Idaho, Colorada, and Montana	Public	Dentistry, Medicine, Nursing, Pharmacy, and Physical Therapy
Western New York Geriatric Education Center	State University of New York at Buffalo Buffalo, New York	Western New York	Public	Dentistry, Medicine, Nursing, Occupational Therapy, Pharmacy, Physical Therapy, and Social Work
Western Reserve Geriatric Education Center	Case Western Reserve University Cleveland, Ohio	Northeast Ohio	Private	Dentistry, Medicine, Nursing, Pharmacy, and Social Work

CENTER FOR NURSING RESEARCH

Mr. Pursell. We set aside $5 million for the Nursing Center. Where is it? Is any being used for the transition operation?

Mr. Kelso. Mr. Walsh.

Mr. Walsh. It is currently proposed for rescission. It is in our budget.

Mr. Pursell. You have not used any of the funds yet?

Mr. Walsh. This agency was not able to. We still carry it. Should it not be rescinded, we will transfer it to NIH.

Mr. Pursell. You do not need any legislative authority?

Mr. Kelso. The NIH legislation is the authority for the center. That would be the authority we would use to transfer it to NIH.

Mr. Pursell. Thank you.

PROPOSED EXPANDED PRIMARY CARE BLOCK GRANT

Mr. Early. While the President's budget continues to propose a primary care block grant, the Congress seems unlikely to approve this request.

Would you explain how your budget request for this block grant should be allocated among the existing programs—community health centers, for example—if the block grant is rejected?

Mr. Kelso. In 1987?

Mr. Early. Yes.

Mr. Kelso. May I submit it for the record?

Mr. Early. Yes.

Tell us how you do it without money.

[Information follows:].

If the expanded primary care block grant proposal is not approved, the categorical programs for fiscal year 1987 would be as follows:

	Dollars
Primary care block grant/community health centers	375,000,000
Black lung clinics	3,300,000
Migrant health	44,300,000
Family planning	142,500,000
Total, primary health care programs	565,100,000

COMMUNITY HEALTH CENTERS

Mr. Early. Assuming your rescission proposal is rejected, community health centers will receive $396 million in FY 1986?

What level of Federal funding would be required in FY 1987 to maintain FY 1986 service levels in terms of the number of centers and numbers of clients served?

Dr. Martin. We can submit a more complete answer for the record, but our present estimate, of course, based on the House action yesterday, was at a level of $405 million. Adaptations can be made in the base. We can provide detailed information.

Mr. Early. Also include a table in the record at this point for fiscal years 1981-1987 showing the appropriation for community health centers, the total operating budget for these centers, the number of centers and the population served by these centers.

Dr. Martin. We will be glad to.

[Information follows:]

FEDERAL FUNDING OF COMMUNITY HEALTH CENTER (CHC's)

In the event that the proposed rescission of $21 million is not approved in FY 1986, approximately $405 million would be needed in FY 1987 to continue services at the FY 1986 level of activity.

[Dollar amounts in millions]

Fiscal year	Approriation	Jobs bill	Centers operating budget	Number of CHC's	Total users
1982	$281		$601	549	$,500,000
1983	295	$65	691	588	4,800,000
1984	341	10	757	590	5,000,000
1985	383		766	590	5,200,000
1986	[1] 375		[2]	550	5,150,000
1987	[3]				

[1] Appropriation of $400 million was reduced by $4 million for sequestration and an additional $21 million proposed for rescission in FY 1986.

[2] The full-year cost of this activity is not available at this time.

[3] Proposed legislation would consolidate the CHC, Migrant Health, Black Lung Clinics and Family Planning categorical grant programs into a single Primary Care Block Grant in FY 1987.

NATIONAL HEALTH SERVICE CORPS

Mr. **EARLY**. Your 1987 budget request for the National Health Service Corps is $9 million less than currently available in 1986. Would you explain for the Committee how this $47 million request was calculated?

Mr. **KELSO**. This is a very complex matter in that we have PPOs, PPAs and Federal employees. How many are on the Federal payroll and how many are not determines the budget. We continue to give high priority to the PPO program and the PPA program which means the individuals are non-Federal employees. To the degree we can do that, the budget request is adequate.

Mr. **EARLY**. Also tell us the total number of Corps personnel and where they are practicing.

Dr. **MARTIN**. We will be glad to.

Mr. Early. Also include in the record at this point a table for FY 1981 to FY 1987 showing the total size of the Corps and the distribution of Corps personnel by type of placement.

Dr. **MARTIN**. We will be glad to.

[Information follows:]

NATIONAL HEALTH SERVICE CORPS

Budget requests for the National Health Service Corps program reflect, for the most part, the salary and benefit requirements of the Federally employed portion of the NHSC program. Given the capacity to match newly available obligors with positions in communities as identified on the Health Manpower Shortage Area (HMSA) Placement Opportunity List (HPOL) (Federally and non-Federally supported vacancies), the program is able to project changes in Federal employment levels to provide for the annual employment cost. Included in these annual estimates are costs associated with overhead related to assignee travel and transportation, supplies, technical services, etc. as well as the NHSC loan programs.

The FY 1986 appropriation had provided $58.5 million for the NHSC program, a level that has been reduced by $2.5 million for sequestration and by another $2.4 million proposed for recission in FY 1986. However, the revised estimate continues to be much larger than required by NHSC program. Therefore, a surplus of $8.3 million has identified that is tentatively available for reprogramming to the CHC program with the remaining $45.2 million available for the NHSC field program in FY 1986.

With program emphasis continuing to focus on non-Federal employment in the Private Practice Option and Private Placement Assignment programs, estimated field strengths and budget requests for the NHSC Federal field program are projected to remain relatively constant from FY 1986 through FY 1987.

COMBINED NHSC FIELD STRENGTHS BY URBAN/RURAL SETTINGS

Area	1984	1985	Estimate 1986	Estimate 1987
Urban	1,105	1,160	1,313	1,259
Rural	1,504	1,798	1,991	2,033
Total	2,609	2,958	3,304	3,292

DISTRIBUTION OF NHSC PERSONNEL BY TYPE OF PLACEMENT

	1981	1982	1983	1984	1985	Estimate 1986	Estimate 1987
Federal	1,926	1,891	1,452	747	539	571	571
PPO	412	891	1,101	1,104	888	698	459
PPA			312	758	1,531	2,035	2,262
Total	2,338	2,782	2,865	2,609	2,958	3,304	3,292

Mr. EARLY. How much of the fiscal year 1986 and 1987 community health center budget is being used to support Corps personnel?

Dr. MARTIN. We would have to provide for the base of those physicians already on board. It is anticipated that the additional assignees being assigned to community health centers would have been covered with a reprogramming from the National Health Service Corps.

As I think I indicated in the previous response to the Chairman, it would be necessary if the $21 million were rescinded to essentially bring on the 400 to 450 community health center doctors as Federal employees. We could cover it in 1986 without an increase, but it would require a supplemental increase in 1987.

Mr. EARLY. So give the exact number for 1986.

Dr. MARTIN. Certainly.

[The information follows:]

COMMUNITY HEALTH CENTERS (CHC) Support for the NHSC Personnel

Were the proposed rescission of $21 million to the CHC program not approved, approximately $78-$82 million of the $396 million available would be used to support Corps personnel employed in CHCs in FY 1986.

Mr. EARLY. The number of pure private practice placements is declining steadily—from 518 in 1983 to less than 50 in 1987.

Why cannot more scholarship people be placed in unsubsidized private practice?

Mr. KELSO. The private practice option, or PPO, is our number one priority. We have done very well in that area. The difficulty is that the number of health manpower shortage areas is decreasing. Some of the people placed under the PPO are continuing to stay. Some private physicians are moving into these areas, therefore the availability of the slots is going down.

Mr. EARLY. If Congress directed 250 pure private placements in fiscal year 1987, could you meet that target?

Mr. KELSO. We would have to take a look and supply it for the record.

[The information follows:]

Due to the limited number of PPO vacancies identified on the Health Manpower Shortage Area Placement Opportunity List (HPOL), 250 PPO placements could not be attained.

Mr. EARLY. The budget documents indicated that you hope to place 990 new scholarship recipients in fiscal year 1987.

What is the current Federal cost for each type of placement?

Mr. KELSO. The Federal employee is somewhat in excess of $50,000 a year. Those in community health centers are somewhere around $40,000.

HEALTH EDUCATION ASSISTANCE LOANS (HEAL)

Mr. EARLY. Turning to the HEAL program, your budget indicates that loan volume will increase from $271 million in 1985 to $389 million in 1986. The fiscal year 1987 budget proposes, however, to reduce this by 74 percent to $100 million.

What effect would you expect this change to have on the 30,000 students who would be cut off from loans?

Mr. KELSO. They would have to find alternatives to the HEAL loan.

HEALTH PROFESSIONS STUDENT LOANS (HPSL)

Mr. EARLY. Are there alternatives?

Mr. KELSO. We have the HPSL and I am sure there are other State and local programs. Most students use a variety of sources to finance their education. In addition, there is the guaranteed student loan program which is administered by the Department of Education and, of course, their own support mechanisms.

Mr. EARLY. Do you have any reservations? With $20,000 tuition, wouldn't many students have to drop out?

Mr. KELSO. They would have to find other sources or go to the State university institutions that do not have a $20,000 tuition.

HEALTH EDUCATION ASSISTANCE LOANS (HEAL)

Mr. EARLY. You are an excellent administrator, but they have quotas. This HEAL program is a threat.

Would you rather have great guys with a poor budget or bad guys with a good budget? I would lean toward the latter.

I am sure Mr. Natcher will not accept that. That is really going to set out where we change from the thirties making a medical school and health professions available to everybody, not just the rich.

HEAL RISK SHARING

The appropriation language proposes to limit the Federal guarantee to 80 percent of the loan.

Tell us why this is being proposed and also tell us whether you believe banks would continue to participate if the guarantee was set at 80 percent?

Mr. **Kelso**. We believe they will participate. We have not tested it, but I believe they will.

LOAN DEFAULT RATES

Mr. **Early**. That is a lot more positive than your earlier suggestion.

On page 114 of the justification, you indicated that you are reviewing the cases of 1,400 HEAL loan defaults.

What is the current default rate in the major loans programs handled by your agency and how does this compare to the rate two years ago?

Mr. **Kelso**. The National Health Service Corps default rate is about 16 percent. There are about 1,500 in default of which five hundred did not complete their training. Mr. Hatch also had the numbers on HPSL.

Mr. **Hatch**. The delinquencies are at 4 percent. On the nursing program, it is 18 percent. On HEAL it is about an 8 percent default rate.

Mr. **Early**. When we look at HEAL, and if we go back to the years of high inflation, youngsters were coming out with loans and debt service in excess of $100,000.

Are you giving them a little more leeway so far as repayment? Are we trying to be fair?

Mr. **Hatch**. Certainly we are fair. The principal responsibility for collection of the loans lies with the lenders, and if the lenders have difficulty in collecting, then the loan is referred to us for pre-claims assistance. We have been very successful between us and the lenders in curing a lot of the delinquency before it goes into default. We cure about 80 percent through this pre-claims assistance where we get involved in writing to borrowers, writing to lenders, and informing the borrowers if they do not get back on track, the government will take over the collection process.

Once the government takes it over, we are fully responsible for the collections.

Mr. **Early**. Give us a breakdown of what your assumptions are as far as numbers and dollar volumes, please.

Mr. **Hatch**. Yes.

[Information follows:]

HEALTH PROFESSIONS GRADUATE STUDENT LOAN AND INSURANCE PROGRAM, SEP. 30, 1985

	Borrowers	Amount
1. Loans in repayment at lenders [1]	11,219	$146,701,203
2. Loans delinquent more than 60 days held by lenders	1,140	$19,402,548
3. Delinquency rate (line 2 divided by line 1) (percent)	10.2	13.2
4. Loans in default [2]	739	$13,203,000
5. Default rate (line 4 divided by sum of line 1 plus line 4) (percent)	6.2	8.3
6. Total claims paid (line 4 divided by sum of line 1 plus line 4) [3]	781	$14,177,000
7. Claims rate (line 6 divided by sum of line 1 plus line 6) (percent)	6.5	8.8

[1] Includes all Health Education Assistance Loans which have entered repayment since the inception of the program.

[2] These figures represent loan receivable held by the Department. Excludes claims forgiven by statute (death and disability), three loans repaid in full by defaulted borrowers, one loan discharged in bankruptcy before 1981, and one loan written off as uncollectible.

[3] Reflects all claims paid (default, death, disability, bankruptcy).

Mr. **Early**. How many schools have been or are about to be dropped from the program due to excessive default rates?

Mr. **Hatch**. Are you referring to the application of our performance standard on the HPSL student?

Mr. **Early**. In nursing and HPSL.

Mr. **Hatch**. We have not applied the performance standard to nursing. That will not begin until June. Schools have a year to bring themselves within the performance standard before we take termination action, so we have not yet begun the process with the nursing schools.

In the case of health professions, we had 15 schools out of the 313 that participate that have not met the performance standard.

Mr. **Early**. How many are private? How many are public?

Mr. **Hatch**. There are seven pharmacy schools, three medical schools, one osteopathic school, one dental school, and one podiatry school. They are a mixture of public and private.

Mr. **Early**. Of the latter how many are public?

Mr. **Hatch**. Suny-Stonybrook Medical—public. Meharry—private. University of Puerto Rico, it is public. Let me qualify the University of Puerto Rico. We do not have information from them. The University of Puerto Rico Dental and Meharry Dental Schools, they are the medical and dental schools.

The osteopathic school is the Iowa school. It is public.

HEAL AND LOAN GUARANTEES

Mr. **Early**. Has the full amount of new HEAL loan guarantees for fiscal year 1986 been released to the lenders?

Mr. **Hatch**. Not yet.

Mr. **Early**. When will it be?

Mr. **Kelso**. We are in the process of releasing it. Hopefully it will be complete within the next few weeks.

Mr. **Early**. Why the delay?

Mr. **Kelso**. Well——

Mr. **Early**. Is it OMB?

Mr. **Kelso**. There is language in the continuing resolution which says that the money should not go through the apportionment process. We are proceeding on that basis. OMB is not the problem.

LOAN DEFAULT RATES

Mr. **Early**. Insert in the record at this point a summary of current default rates in each program and an update on your efforts to reduce the default rates over the last two years.

[Information follows:]

Debt Management Efforts

Health Education Assistance Loan (HEAL) Dollar Claims Rates, Sept. 30, 1985—8.8%.

Health Professions Student Loan (HPSL)/Nursing Student Loan (NSL) Dollars Delinquency Rates (60 days), June 30, 1985—HPSL, 4.03%; NSL, 18.13%.

Efforts to reduce HEAL defaults over the last two years:

The Bureau has:

Developed a comprehensive NPRM defining extensive due diligence requirements for lenders and schools. The NPRM should be published by 4/15

Conducted six national workshops for lender and school officials. In excess of 150 officials attended these workshops

BEST COPY AVAILABLE

Issued numerous policy memoranda identifying school and lender problems and providing solutions

Conducted five workshops in Rockville for lender and school officials

Developed a comprehensive quarterly report for lenders to provide program information. The report is presently in clearance channels

Efforts to reduce HPSL/NSL delinquency rates over the last two years:

The Bureau has:

Issued revised NSL program regulations which establishes a delinquency performance standard

Issued due diligence regulations for both (HPSL and NSL) programs

Conducted nine national workshops concentrating on due diligence and effective loan collection and program management. In excess of 800 school officials were in attendance

Issued three definitive policy memoranda addressing due diligence and effective loan collection techniques

Made formal presentations to national and regional meetings of school officials

Conducted 200 program reviews of troubled programs

FEDERAL EMPLOYEE OCCUPATIONAL HEALTH

Mr. EARLY. Last year you proposed to terminate the Federal employee occupational health program. Congress rejected this but did approve the plan to fund these activities entirely from user fees.

What are your plans in fiscal year 1987 for this program?

Mr. KELSO. They are continuing. We are on schedule to place the program on a reimbursable basis by 1989. We hope that the contracts will be written and they will meet the objective.

Mr. EARLY. Will the reduction of 78 FTEs for the Occupational Health Office require a reduction in force?

Mr. KELSO. I will let Dr. Martin answer it.

Dr. MARTIN. It was on a five-year plan through 1989. That was approved by the OMB. The anticipated level of positions based on that approved by your plan was somewhere between 109 and 210 based on attrition. With 109, there would be no difficulty because they are reimbursed. Unless something surprising happens with attrition, we would have to take a look at the possibility of a reduction in force.

Mr. EARLY. Will you inform the Committee as soon as you know the numbers?

Dr. MARTIN. Yes.

[Information follows:]

After further review of the FEOH current staffing and of plans for program adjustments through Fiscal Year 1987, and after consultation with representatives from the Office of the Secretary, we have been able to determine that the continued evolution of the FEOH program will be accomplished without resorting to a Reduction-In-Force or any other type of adverse personnel action.

USER FEES

Mr. EARLY. Mr. Kelso, your budget assumes $10 million of savings as a result of charging user fees to process requests for HMO and facility loan applications.

Would you explain how this will work and whether it requires legislation?

Mr. KELSO. Dr. Whiteside?

Dr. WHITESIDE. We have authority to charge user fees now; we need legislation to allow us to keep the money and spend it ourselves as opposed to returning it to the Treasury.

Mr. **Kelso**. The HMO applicants and those applicants for the competitive medical plans receive the benefits of this activity. Therefore, they should be charged a user fee. It is necessary for the money to come back into our appropriation so we can support the staff to carry on the work.

Mr. **Early**. What do you think about that approach?

Mr. **Kelso**. I think it is fine.

Mr. **Early**. Would you think it is a good process for other administrators? That is merely a revolving fund?

Mr. **Kelso**. I think that when certain segments of our society benefit monetarily from the government service, they should be considered for a user fee.

Mr. **Early**. Do you follow that through and say in most of the disciplines we should go along with that?

Mr. **Kelso**. I could not draw that analogy, but I can do it on the one we are proposing.

GILLIS W. LONG HANSEN'S DISEASE CENTER

Mr. **Early**. Two years ago, the Department submitted to the Committee a long-range plan for the Hansen's Disease Center recently named after Congressman Gillis Long.

Tell us, if you will, what progress has been made in implementing this plan?

Mr. **Kelso**. We are continuing to have institutional admissions at the Hansen's Disease Center in Carville, but we are trying to go more to an outpatient basis. The average patient load stays about the same level. Our long-range objective would be to deinstitutionalize.

Dr. **Martin**. We can submit a status report on that particular long-range program.

[Information follows:]

The Future Role of the Gillis W. Long Hansen's Disease Center

This is a report on the activities conducted at the Gillis W. Long Hansen's Disease Center (GWLHDC) to carry out recommendations contained in the report submitted to the Congress in 1983.

Recommendation 1. Continue the Federal HD effort at present levels.

Discussion: Epidemiological evidence indicates a continuing increase in the incidence of HD in the U.S. This has resulted in an increase in the number of admissions during the last five years as well as an increase in the number of cases first recorded in the HD Register.

Table 1 shows the admissions, patient days, census, and length of stay data for the five year period 1981-1985. Reductions in patient days and length of stay in the table are reflected in the average daily census figures and show a substantial improvement in program performance based on improved utilization review.

Tables 2 through 9 provide additional information about the incidence and distribution of HD based on information in the HD registry.

Recommendation 2. Rely increasingly on Regional HD Centers.

Discussion: The Regional Hansen's Disease Program (RHDP) had its origin in the development of local sites for the care of HD patients following termination of the PHS general hospitals. The program was formally established in 1983 in furtherance of the concept of providing HD care in the individual's home community. Under this program, the HD patient can receive treatment for his or her condition, remain with the family, and continue employment. This disruption, and facilitates necessary therapy. The GWLHDC is reserved for patients requiring therapy or resources not available in the local community, for specialized diagnosis, and for the treatment of complicated cases.

The RHDP impacts the Center in 3 ways: patient care; drug distribution; and consultation and teaching. The following workload has been identified with the RHDP at the GWLHDC:

	Admissions	Prescription Services	Telephone Consultations
1983	5	1,405	145
1984	60	1,508	190
1985	82	1,611	212

Recommendation 3. Establish at the GWLHDC an active program of utilization review.

Discussion: A subcommittee of the Utilization Review Committee was established in June 1984 to review patients who had been hospitalized for 2 years or longer at Carville. The committee consists of 3 members, 2 physicians and a social worker. The committee meets monthly and reviews 10 patients per month. The purpose of the committee is to evaluate long-term patients for possible discharge.

As of March 1986, 200 patients had been reviewed. The committee determined that 127 of these patients required continuing hospitalization and need not be reviewed again. Forty patients were selected to be re-reviewed in 1 year and 27 in 2 years. Four of the original 200 patients have died. Eight patients have been discharged following review by the committee.

Recommendation 4. Establish a national HD data and epidemiologic program.

Discussion: The National Hansen's Disease Registry is an automated dynamic patient data system containing descriptive personal and treatment information about each HD patient and their household contacts reported or admitted to the GWLHDC since 1950. The system was established in January 1983 and automated in August 1984. The Registry receives patient data from the CDC Leprosy Surveillance system; the GWLHDC's admissions, drug distribution, telephone consultation and biopsy reading programs; and the Regional Hansen's Disease Centers.

The Registry enumerates known HD patients in the U.S. through periodic reports showing who the patients are by classification of HD, sex, race, age groups, birthplace, current residence and source of treatment. The tracking system is updated using billing data from the Regional Centers.

Recommendation 5. Establish an HD Scientific Group to oversee the research conducted at the GWLHDC.

Discussion: In July 1983 a proposal was approved by the Assistant Secretary for Health for an HD Research Advisory Committee (HDRAC) to be formed for the purpose of providing a peer review mechanism for HD research conducted by staff members of the Bureau of Health Care Delivery and Assistance (BHCDA) of the Public Health Service, which includes staff of the GWLHDC, and research proposals submitted by physicians on contract to BHCDA which involve HD patients under their care. The committee consisted of 13 members from organizations including the Centers for Disease Control, the Armed Forces Institute of Pathology, the National Institutes of Health, and the GWLHDC.

The first meeting of the HDRAC was held on October 20-21, 1983 at which time the quarterly reports of the Laboratory Research Branch, GWLHDC, were reviewed together with a number of proposals and collaborative projects. The committee also made a number of policy recommendations. The committee has subsequently met on August 15-17, 1984, and August 17-18, 1985, with similar agendas.

Recommendation 6. Treatment provided at the Gillis W. Long Hansen's Disease Center should be reimbursed by Health Insurers.

Discussion: Legislation to authorize the GWLHDC to be reimbursed by health insurers is pending in the Department. No final decision has been reached on the proposal.

TABLE 1

STATISTICAL DATA FOR 1981-1985

YEAR	DISCHARGES +DEATHS	ADMISSIONS	INPT. DAYS	AVERAGE DAILY CENSUS	LENGTH STAY
1981	148 (5)	136	84,018	230	568
1982	180 (16)	162	82,167	225	456
1983	184 (10)	160	79,709	218	433
1984	163 (7)	144	76,425	209	469
1985	165 (10)	182	75,456	207	457

LENGTH OF STAY OF FIRST ADMISSIONS

DAYS	Year 1973 No.PTS.	1981 NO.PTS.	1982 NO.PTS.	1983 NO.PTS.	1984 NO.PTS.	1985 NO.PTS
1 - 7	5 (11%)	15 (27)	12 (19%)	18 (33%)	14 (26%)	20 (22%)
8 - 14	6 (13%)	13 (23%)	21 (32%)	11 (21%)	18 (34%)	20 (22%)
15 - 30	8 (17%)	14 (25%)	10 (15%)	7 (13%)	4 (8%)	19 (21%)
31 - 60	5 (11%)	5 (9%)	10 (15%)	7 (13%)	4 (8%)	14 (16%)
61 - 90	5 (11%)	4 (7%)	2 (3%)	4 (7%)	4 (8%)	4 (5%)
91 - 120	3 (7%)	0	2 (3%)	1 (2%)	2 (4%)	2 (2%)
121 - 150	5 (11%)	3 (5%)	1 (2%)	2 (4%)	2 (6%)	3 (4%)
151 - 180	1 (2%)	0	0	0	1 (2%)	0
181 - 365	8 (17%)	2 (4%)	7 (11%)	4 (7%)	3 (6%)	7 (8%)
	45	56	65	54	52	89

March 20, 1986
0543M

TABLE 2

HANSEN'S DISEASE IN THE UNITED STATES
BY DISEASE CLASSIFICATION, 1951-1984
TOTAL CASES = 5126

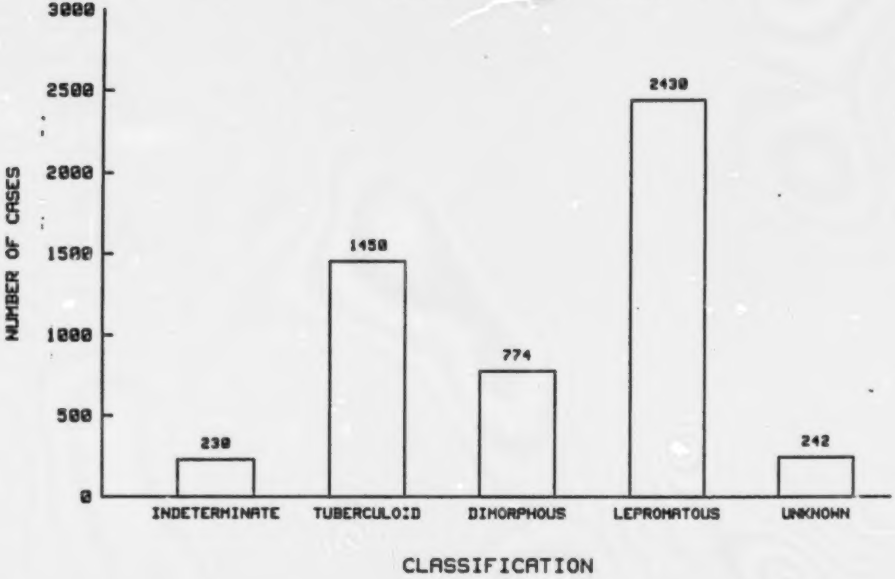
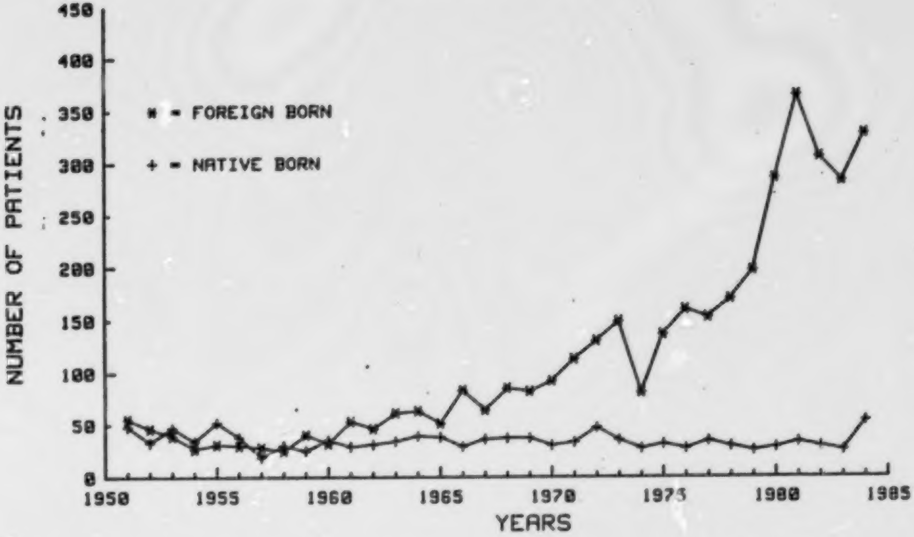


TABLE 3

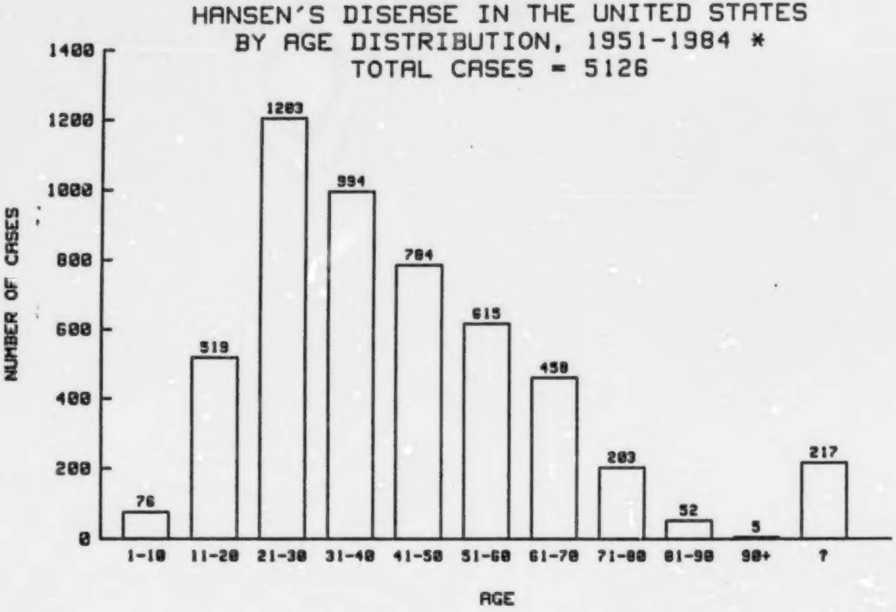
HANSEN'S DISEASE IN THE UNITED STATES
BY PLACE OF BIRTH
TOTAL CASES = 5126 *



* 94 CASES IN 1982-1984 IN WHICH BIRTHPLACE NOT REPORTED

44

TABLE 4



HANSEN'S DISEASE IN THE UNITED STATES
BY AGE DISTRIBUTION, 1951-1984 *
TOTAL CASES = 5126

* AGE WHEN ADMITTED OR REPORTED

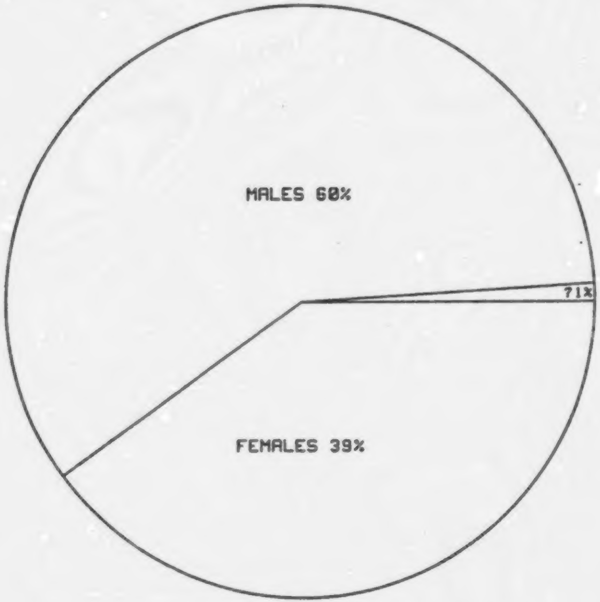
BLANK PAGE

BLANK PAGE

BLANK PAGE

TABLE 5

HANSEN'S DISEASE IN THE UNITED STATES BY SEX CLASSIFICATION, 1951-1984

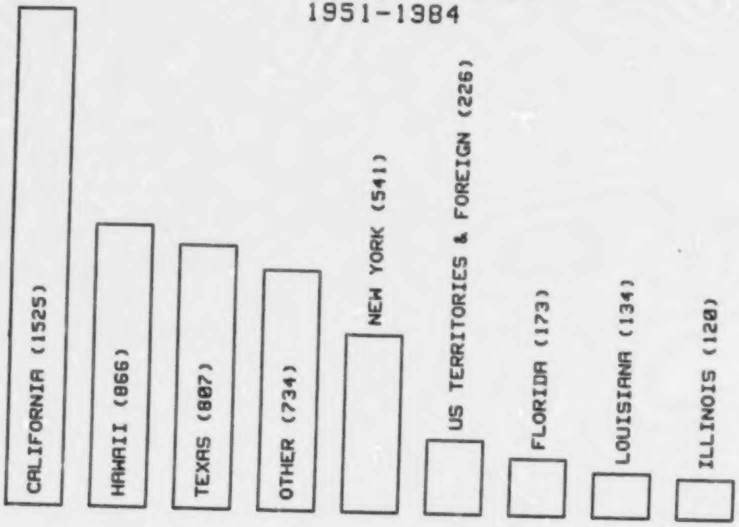


TOTAL REPORTED CASES = 5126

46

TABLE 6

RESIDENCE WHEN REPORTED TO
NATIONAL HANSEN'S DISEASE CENTER
TOTAL CASES = 5126
1951-1984



NO CASES FROM ALASKA

TABLE 7

BIRTHPLACE OF NATIVE-BORN HANSEN'S DISEASE PATIENTS
REPORTED 1951-1984
TOTAL = 1157

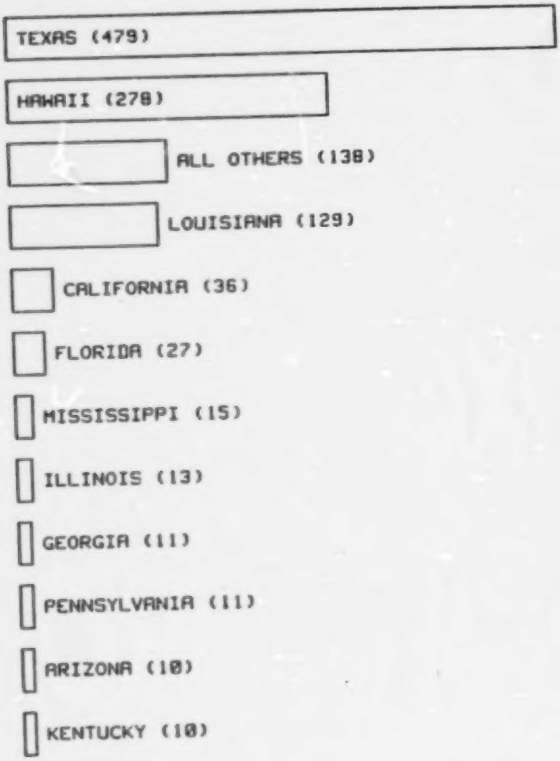


TABLE 8

REPORTED HANSEN'S DISEASE PATIENTS 1951-1984
BIRTHPLACE OUTSIDE THE UNITED STATES
TOTAL CASES = 3969

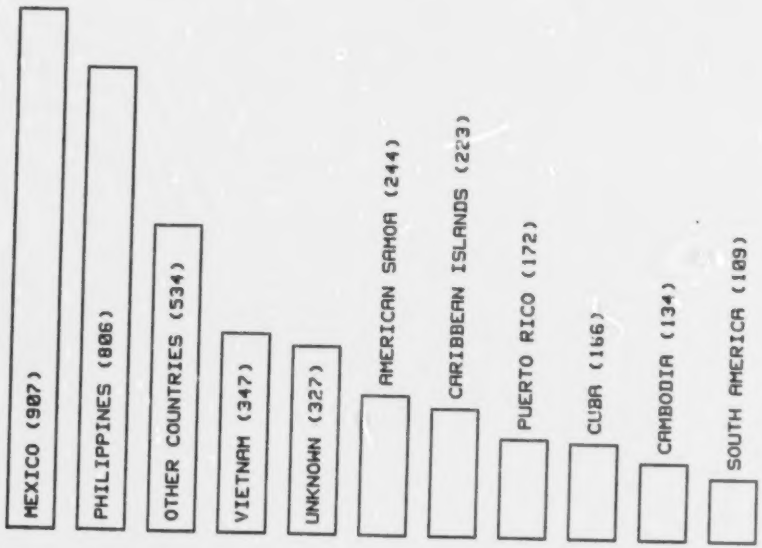
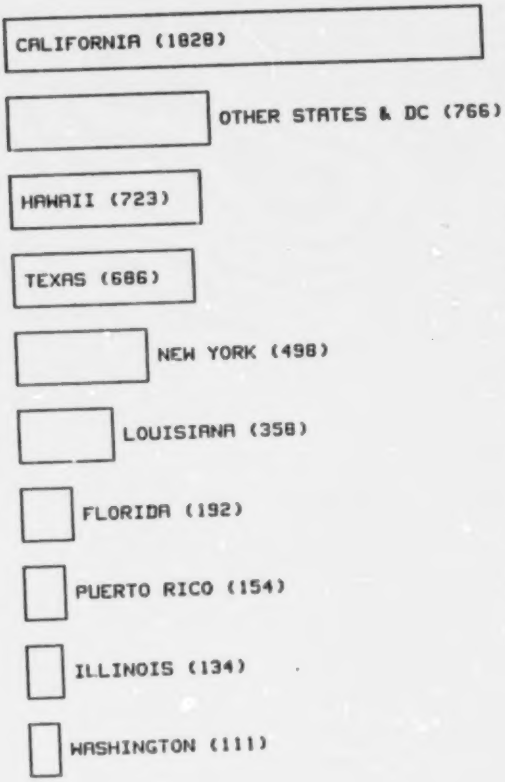


TABLE 9

LOCATION AND NUMBER OF HANSEN'S DISEASE PATIENTS RESIDING IN U.S., FEBRUARY 1986
TOTAL PATIENTS = 5450



Mr. **Early**. Your report indicates that the number of new cases of Hansen's Disease is less than 300 per year, of which less than 60 are persons born in this country.

What do these numbers indicate in terms of the future role of the center as a residential facility?

Dr. **Martin**. The incidence has increased, but the observation of indigenous people continues to be correct. It is largely case findings in populations other than United States natives. The anticipation is that although there is a five to seven year lag in diagnosis, the hospitalization or institutionalization would continue to decline over the next five to 10 years as the Carville population continues to leave. Relatively few people are required to be cared for in the institutional fashion.

The history of the treatment has changed. It used to be forced. Now the entire program design is to provide care for individuals in their communities, most of which are not in institutions.

Mr. **Early**. Yesterday the Secretary suggested that we are testing immigrants for Hansen's disease.

Dr. **Martin**. No. It is a difficult diagnosis. It is further a disease which cannot be detected for five, 10 or 15 years after exposure.

The number of people qualified to make the diagnosis and the effectiveness of the testing has increased.

It would be difficult to make that diagnosis as a precondition of entrance.

Mr. **Early**. Yesterday, Dr. Bowen said we were not admitting people to this country with Hansen's Disease.

Dr. **Martin**. If an individual has already been diagnosed as an individual with Hansen's Disease, that presently is a disqualifying entry condition.

But, as I indicated before, unlike many other things for which you can run a simple blood test, Hansen's Disease is very difficult to diagnose, and until you actually have tissue damage, it is almost impossible to diagnose.

If an individual were detected to have Hansen's Disease and it was diagnosed, that would be a way. But there is no way other than tissue examination after a suspected lesion. There is no way to detect it. It could be 10 or 15 years before you actually have the clinical manifestation of the disease.

BUILDINGS AND FACILITIES

Mr. **Early**. What are your plans over the next five years for renovation of facilities at the center?

Mr. **Kelso**. I will be glad to supply that information.

[Information follows:]

Health Resources and Services Administration 5-year proposed facilities master plan for Gillis W. Long Hansen's Disease Center

	1985 cost estimates
A. *First Year:*	
New Construction: New Laboratory Research Facility	$8,500,000
Repair and Improvement of Existing Facilities	1,200,000
B. *Second Year:*	
New Construction: Animal Care Facility	3,300,000
Repair and Improvements	2,900,000

	1985 cost estimates
C. *Third Year:*	
New Construction: Infirmary Addition	1,600,000
Repair and Improvements	3,900,000
D. *Fourth Year:*	
New Construction: Service Buildings	1,100,000
Repair and Improvements	4,500,000
E. *Fifth Year:*	
New Construction:	
Animal Care Facility	1,800,000
Enclosed Walkway	100,000
Repair and Improvements	3,100,000

The FY 1987 budget includes $750,000 for recurring maintenance and repair.

Mr. EARLY. Given the increasing role of research at the center, would it make sense to transfer this facility to the National Institutes of Health?

Mr. KELSO. The institution provides care. I would not see it going to NIH at the present time.

EMPLOYEES SPECIAL PAY AT HANSEN'S DISEASE CENTER

Mr. EARLY. Your budget request for Carville is $19,103,000.

Does this assume any change in the method of payment for employees at Carville?

Mr. KELSO. The employees at Carville for years have received what we call special pay. We have instituted a special policy whereby new employees at the center will not receive special pay.

Current employees, if they are commissioned officers, will receive $110 a month over base pay. Civil Service employees will receive a minimum of the same $110 over base pay as the commissioned officers, and their salaries will he held constant over time by not giving them increases until such time as their special pay no longer exceeds $110 per month over other civil service employees.

Mr. EARLY. Will any of this need legislation?

Dr. MARTIN. That requires a statutory change which was effected. Subsequent to that, the changes for Civil Service employees required regulation by the Department. That has been accomplished.

NURSING RESEARCH

Mr. EARLY. For each of the last several years, Congress has provided close to $10 million for nursing research projects. This is separate from the $5 million recently approved for the new National Center for Nursing at NIH. Your budget proposes to terminate both of these activities.

What results have you seen from the nursing research money which has been spent in the past?

Mr. HATCH. I think there have been good results overall. There are a number of studies that have supported the program that have identified a variety of methods for treating people more effectively.

One program that is currently going on in coordination and in cooperation with the National Institute on Aging is a large activity to learn more about and trying to do a better job of controlling incontinence in older people. There are a variety of research studies focusing on improving service, more cost-effective service and management of nursing programs.

Mr. Early. For the record will you expand on a few of the projects in detail?

Mr. Hatch. I will be glad to.

[Information follows:]

EXAMPLES OF NURSE RESEARCH GRANT PROJECTS

School nurses teaching elementary school children about caring for themselves has been shown to make the children both healthier and better able to communicate with health professionals when they seek care. This project was carried out at the University of Colorado, and it produced audio-visual materials which can be used by the school nurse in both individual and classroom counseling of the children.

Systematic exercise programs for the elderly have been demonstrated to increase both morale and physical condition. In a project at Ohio State University, the exercises were tailored to requirements of the older person so that floor mat exercises were available to the ambulatory, in-chair exercises for the more limited individuals, and in-bed exercises for those who needed them.

The goal of research underway at the Oregon Health Sciences University is to develop and test nursing intervention strategies to prevent or decrease strain on family caregivers and to extend their ability to continue providing care. The project is significant from the perspectives of both nursing and health services research because it focuses on two significant population groups: frail, ill, elderly persons at home and middle-aged family members who are responsible for their long-term care.

The relationship between job stress and personal factors relating to the ability of neonatal intensive care nurses to cope with tension is being studied in order to answer important questions about retention of nurses in these units. The findings from this study at the University of Oklahoma have practical significance for job counseling of nurses to be employed in neonatal intensive care units.

At the University of Pennsylvania, research is being conducted to assess the cost effectiveness of bladder training therapy. Three outcomes have been identified to measure effectiveness of the training: changes in the frequency of incontinence, changes in personal, psychological and physical functioning, and changes in personnel and material resources required for caring for patients. Findings from the study will be useful to nurses, their patients, and policymakers.

EQUIPMENT COSTS AND CONTROL

Mr. Early. If you will turn for a minute to the object class table on page 21 of the justifications.

This table indicates that during the period 1985 to 1987, you will spend $4.7 million on equipment.

Will you explain what types of equipment are involved and how their costs are controlled within the agency.

Mr. Kelso. Mr. Walsh.

Mr. Walsh. On page 11, my line item for equipment shows $2 million.

Mr. Early. But over the three years $4.7 million?

Mr. Walsh. The total of the three years—this equipment would range from medical equipment to ADP equipment to various office equipment. This is for the entire appropriation.

Mr. Early. Are there separate budget controls for the equipment?

Mr. Walsh. Yes.

Mr. Early. Expand on that for the record as far as the process is concerned.

Mr. Walsh. All right.

[Information follows:]

Each bureau within the Health Resources and Services Administration prepares a budget plan based on the allotment received for the fiscal year. Within this plan, administrative controls on discretionary spending for equipment purchases and rentals, as well as other categories, have been limited to the highest priority items as necessary.

TRAVEL COSTS AND CONTROL

Mr. **Early**. This table also shows over $5.3 million for travel and transportation of persons in 1985 and $4.6 million in 1986.

Will you explain how these costs are controlled and also tell us how these travel budgets compare to prior years?

Mr. **Walsh**. We can do that for the record.

Mr. **Early**. Also insert in the record at this point a table showing travel costs for fiscal years 1981 and 1986.

Mr. **Walsh**. Yes, sir.

[Information follows:]

Administrative controls on descretionary spending for travel have been limited to the highest priority items as necessary. Travel is being permitted only as necessary to effectively manage programs by requiring travel order review at the level of the Bureau Director.

The travel costs for fiscal years 1981 through 1986 are as follows:

Year:	*Cost (thousands)*
1981	$7,479
1982	4,652
1983	4,530
1984	5,305
1985	5,335
1986	4,579

INCREASED COST IN ADMINISTRATION

Mr. **Early**. Mr. Pursell.

Mr. **Pursell**. No further questions.

Mr. **Early**. According to the summary of changes table, you have budgeted for an increase of $2,677,000 for several administrative categories, including rent, phones and utilities. This is hard to understand since you are proposing a 25 percent decrease in the size of the staff.

Can you explain to the Committee the basis for this cost estimate?

Mr. **Walsh**. That is on page 11. The increases are for the Federal employees' compensation fund, the standard level user charges and the service and supply fund. Although the overall amounts available for overhead items such as these are declining, those particular items tend to show over the years some increases.

The Federal employee compensation fund is really uncontrollable. You have on-the-job injuries from previous years. The FTS represents telephone costs which have a tendency to increase over the recent years like standard user charges, et cetera. Those service and supply funds would be primarily associated with increasing costs of medical supplies, pharmaceuticals.

CONSOLIDATION OF ADMINISTRATIVE FUNDS

Mr. **Early**. Thank you.

Mr. Kelso, last year, the House and Senate agreed on a single consolidated appropriation of funds for salary and expense costs instead of a separate appropriation for each bureau. Your budget goes back to the traditional approach.

Given the uncertainties surrounding your budget, would it make sense to consolidate these again to give you maximum flexibility?

Mr. KELSO. We would be in favor of that.

Mr. EARLY. Insert in the record at this point a table showing the total number of employees at the Health Resources and Services Administration and the total budget for salaries and expenses costs for the years 1982 to 1987.

Mr. KELSO. We will be glad to.

[Information follows:]

Health Resources and Services Administration
Personnel Costs and FTEs
(Dollars in thousands)

	1982		1983		1984		1985		1986		1987	
	FTE	Amount	FTE	Amount	FTE	Amount	FTE	Amount	FTE	Amount	FTE	Amount
Maternal & Child Health Block Grant	---	$ ---	---	$ ---	---	$ ---	---	$ ---	5	$ 71	5	$ 71
National Health Service Corps	1,809	75,669	1,773	74,943	1,188	49,808	616	27,085	600	28,500	600	28,674
National Hansen's Disease Center	308	9,531	390	10,477	381	10,963	382	11,709	384	12,730	384	12,037
Federal Employee Occupational Health	33	895	24	697	25	785	18	600	---	---	---	---
PHS Hospitals and Clinics	566	23,206	---	---	---	---	---	---	---	---	---	---
Subtotal	2,716	109,301	2,187	86,117	1,594	61,553	1,016	39,394	989	41,301	989	40,782
Administrative Services	1,912	101,174	1,802	87,400	1,900	84,148	1,916	91,497	1,830	73,602	1,103	39,730
Total	4,628	$210,475	3,989	$173,517	3,494	$145,701	2,932	$130,891	2,819	$114,903	2,092	$80,512

INFANT MORTALITY RATES

Mr. EARLY. Mr. Kelso, I, as one member, am pleased to see that you have restored $20 million to the budget for Maternal and Child Health. This returns it to the original 1986 appropriation level of $478 million which is the full level authorized. It does not, however, provide any increase to offset inflation over the last three years.

Given the increased concern about infant mortality rates, is this an area Congress should consider adding funds to?

Mr. KELSO. Given the emphasis we are putting on infant mortality, we believe the $478 million is adequate.

Mr. EARLY. Dr. Hutchins, Mr. Stokes talks about lack of decline in minority mortality rates.

What has happened to that?

Dr. HUTCHINS. The rate for blacks is twice what it is for the whites. The last year for which we have figures available is for 1983. That has been a consistent pattern, that the rates continue to reduce over time, but the black rate remains behind.

Mr. EARLY. That makes me suspect we are not doing enough.

If we are solving it everywhere, I would think there must be something more we could do.

Dr. HUTCHINS. We have looked at that very carefully, and when similar factors are controlled, the rates decrease, but there still remains a twofold difference between the black and the white in the mortality rates. It is not clear why that is. We are having discussions with Dr. Posner as to whether there is a method to look at that.

One of the suggestions was that it may be nutritional over generations. You may have to look at several generations.

Mr. EARLY. The answers have been the same for several years. The situation has not gotten any better.

How many studies do we have?

Dr. HUTCHINS. We are actually discussing about having some kind of study on that with the people at Meharry.

Mr. EARLY. We have had enough time to study. We should do something.

Last year we saw an increase in the infant mortality rate which alarmed many people.

What can you tell us about the current data on infant deaths?

If Congress appropriates more money for the maternal and child health program, would States use the funds to expand services or just substitute Federal dollars for State dollars?

Mr. KELSO. They would use the funds to expand services or whatever their needs would be in the State.

Mr. EARLY. From corresponding back and forth, do you see the needs expanding?

Mr. KELSO. I would suspect that they would expand.

FINANCIAL DISTRESS

Mr. EARLY. Insert in the record at this point a historical table showing the total funding for the financial distress program from fiscal year 1981 to fiscal year 1986 broken down by year and school.

Mr. KELSO. We will be glad to.

[Information follows:]

Funding for the Financial Distress Program
for Four Minority Health Professions Schools
($ in thousands)

Schools	FY 1981	FY 1982	FY 1983	FY 1984	FY 1985	FY 1986 1/	Total All Years
Meharry - Medical....	$5,506	$3,340	$3,340	$2,500	$2,500	$1,709	$18,895
Meharry - Dental.....	2,361	2,160	2,160	1,500	1,500	1,139	10,820
Tuskegee - Vet. Med..	1,100	975	1,287	1,157	1,141	697	6,357
Xavier - Pharmacy....	600	629	499	443	399	379	2,949
Total............	$9,567	$7,104	$7,286	$5,600	$5,540	$3,924	$39,021

1/ Reflects FY 1986 After Sequestering Level. The total amount requested for FY 1986 in the Financial Plan is $4,133,000.

FAMILY PLANNING

Mr. **Early**. Your budget request again proposes to consolidate the family planning program into the new primary care block grant.

If this block grant is not approved, how much of your request should be allocated to the family planning program?

Mr. **Kelso**. We will provide that for the record.

[Information follows:]

If the expanded primary care block grant proposal is not approved, $142.5 million should be allocated to the Family Planning program.

Mr. **Early**. Last year, several amendments were considered by the Congress which would have placed limitation on the use of family planning funds. I believe you are familiar with these amendments which in general would have barred funds to organizations which refer individuals for abortions.

What in your view would be the practical effect on family planning programs if this language were to be adopted?

Mr. **Kelso**. Although the family planning program is in our budget, we do not administer it. It is administered by the Assistant Secretary for Health.

Mr. **Early**. Gentlemen, we appreciate your testimony. You are the experts. It will be a difficult year. It is hard to do a job without the tools.

I wish you well.

I thank you for your testimony. We will have some additional questions for the record.

Mr. **Kelso**. We want to thank you and the members of the Committee. We will view this as a challenge.

[The following questions were submitted to be answered for the record:]

ORGAN PROCUREMENT GRANT PROGRAM

Mr. Natcher. The President's budget also proposes to rescind $2,471,000 of funds appropriated to initiate activities under the Organ Transplant Act of 1984. This would allow the "network" to be funded but would not fund the new grants program. Would you explain why you are opposed to an organ procurement grant program?

Mr. Kelso. A viable organ procurement system already exists that is successfully procuring organs for transplantation; Medicare is now supporting this procurement system at a cost of approximately $50-60 million per year. The additional $2.4 million is not necessary. The lack of additional funding will not affect organ procurement in this country. Technically, there is nothing that HRSA funding would support that is not already reimbursable under Medicare.

NHSC PLACEMENTS

Mr. Natcher. If Congress decided that the country could not afford to support 990 new National Health Service Corps (NHSC) placements, could we legally release some of these individuals from their service obligations or provide early release for current personnel?

Mr. Kelso. In answering this question, clarification should be made that the entire 990 new NHSC placements would not be direct cost to the Federal Government. Only 113 are projected to be Federal employees. Fifty are projected to go into Private Practice Option, 727 are projected for Private Placement and 100 are projected for IHS.

With regard to whether some scholarship recipients could be legally released from their service obligation or whether current personnel could be provided early release, according to Title 42, Section 2541(f)(1) and (2) of the U.S. Code, the written contract between the Secretary and the individual scholarship recipient obliges the individual scholarship recipient to serve in a Health Manpower Shortage Area to which he is assigned by the Secretary as a "member of the NHSC" (1 year for every year of support with a minimum of 2 years service), but this is contingent upon the availability of appropriated funds. The written contract between the individual and the Secretary is designed accordingly.

INFANT MORTALITY

Mr. Natcher. Last year we saw an increase in the infant mortality rate which alarmed many people. What can you tell us about the current data on infant deaths both for the general population and for minorities?

Mr. Kelso. The current status is as follows:

- The final infant mortality range for 1983 is 11.2 deaths per 1,000 live births.
- 1973 infant mortality for Blacks is 19.2, for Whites 9.7.

- ° The provisional infant mortality data through September 1985 indicates a decline of less than 3% compared to 4.5% for the 70's.
- ° Post neonatal mortality for 1983 was 3.9, an increase of 2.6% over the 1982 rate of 3.8.
- ° Black post neonatal mortality rose from 6.6 in 1982 to 6.8 on 1984, an increase of 3%.
- ° The 1984 provisional infant mortality rate is 10.6.

The PHS response and activities are as follows:

- ° The MCH Services Block Grant authorizes annual appropriations for allocation to 57 eligible jurisdictions, providing each State the authority to allocate resources based on its own needs.
- ° The National Health Services Corps (NHSC) and the Division of Maternal and Child Health (DMCH) work jointly to identify obstetric and pediatric underserved areas in the [illegible].S. to place obstetricians and pediatricians in medically underserved areas.
- ° Indian Health Service emphasizes early identification of pregnant women and entrance to risk appropriate care. The infant mortality rate for Native Americans dropped from 13.2 in 1980 to a provisional rate of 10.0 in 1984.
- ° Community Health Centers and Migrant Health projects provide prenatal care to medically underserved pregnant women and have implemented a perinatal initiative to ensure delivery of risk appropriate high quality maternal and infant health services.
- ° In FY 1985 SPRANS projects focusing on maternal and infant health were funded for a total of approximately 3 million dollars (Includes 13 EPIC Initiative Grants aimed at strengthening State Perinatal Systems).
- ° In FY 1986, priority will be given to SPRANS projects that focus on: Risk - Appropriate Maternal/Perinatal Care; Early and continuous prenatal care; and post neonatal mortality prevention. Approximately $1.5 million is available for new projects.
- ° A new organizational unit, the Maternal and Infant Health Branch, has been established in the DMCH with responsibility for consultation and technical assistance and analysis and interpretation of data.
- ° Consultation teams have visited Illinois, Arkansas and Nevada. A visit is being planned for Detroit. Visits are made as requested by the States. A variety of other consultations have been provided to Massachusetts, South Carolina, District of Columbia, Philadelphia and other areas.

- The DMCH supports the Health Mothers/Healthy Babies Coalition and the Southern Regional Task Force in Infant Mortality.
- The PHS Low Birth Weight Prevention Work Group, is planning to convene an expert panel to review the content of prenatal care, critique current practices and recommend studies of new or unproven practices.
- The PHS has initiated a National Infant Mortality Surveillance jointly sponsored by CDC, NICHD, NCHS and DMCH. A national conference for State MCH and vital registrar staff to consider implementation of this data is planned for Spring 1986.

FAMILY PLANNING

Mr. Natcher. Last year several amendments were considered by the Congress which would have placed limitations on the use of family planning funds. I believe you are familiar with these amendments which in general would have barred funds to organizations which refer individuals for abortions. What in your view would be the practical affect on family planning programs if this language were to be adopted?

Mr. Kelso. The Family Planning program is in our budget, but is administered by the Office of the Assistant Secretary for Health. I will defer to them on this question.

(Response from the Office of Population Affairs
There are quite a number of these amendments discussed and/or introduced, and several of them were circulated in several different versions. I do not want to try to react to all of them but I would say that I support their overall goal. That goal is to clarify and reinforce the separation between abortion and Federally supported family planning services that Congress intended when it initially included Section 1008 in the Family Planning law.)

COMMUNITY AND MIGRANT HEALTH CENTERS

Mr. Roybal. Since the Primary Care Block Grant is less than the sum of the categorical programs in 1986 (sequestration level), what assurances can you provide--in terms of staffing, size of caseload, and service mix--that the migrant and community health centers can absorb the cost of medical inflation, deal with staffing problems created by the elimination of the National Health Service Corps, and respond to the increased demand likely to be precipitated by other DHHS proposals, such as cuts in Medicaid and the Indian Health Service urban projects? If these additional burdens cannot be absorbed, how many patients will have to be dropped and where do you anticipate that their health needs will be met?

Mr. Kelso. The Primary Care Block Grant proposal for FY 1987 assumes continuation of the same level of total support as is available under our revised 1986 estimate. Under the block grant approach, States are allowed to shift resources among the various activities formerly funded as individual categorical programs. This approach to program management will allow States to continue the highest priority activities within their jurisdiction.

HOME HEALTH

Mr. Roybal. Given the "sicker and sooner" phenomenom, who--if not HRSA--will assume responsibility for curriculum development to keep pace with changes in skills required by changes in home health patient needs? Will Medicare have to take on this function in order to be able to make any future changes in certification requirements?

Mr. Kelso. Under section 339(b) of the Public Health Service Act, HRSA is developing a training module for homemaker home health aides who care for patients using high technology medical devices in the home. This module will be an addendum to the "Model Curriculum and Teaching Guide for the Instruction of Homemaker Home Health Aide." The basic curriculum, and the addendum, is under review by our colleagues in the Health Care Financing Administration.

Mr. Roybal. Since third-party reimbursement is not generally available for home health aides and homemakers, what is the justification for eliminating a residual Federal role in the startup costs for these services?

Mr. Kelso. The HRSA has completed its mission to demonstrate that Federal funds could be efficiently and effectively channeled into areas of high unmet need to increase the Nation's capacity to provide home health services and training of home health services personnel. Allowable startup costs under this program included personnel salaries. Obtaining reimbursement for services was the responsibility of the home health agency.

NATIONAL HEALTH SERVICE CORPS AND NHSC SCHOLARSHIPS

Mr. Roybal. What percentage of the 1985 National Health Service Corps Scholarship recipients are low-income individuals?

Mr. Kelso. We do not collect data on income of scholarship applicants. However, the NHSC Scholarship Program since 1982 has accepted first-time applicants only from the Federal Scholarship Program for First Year Students of Exceptional Financial Need (EFN). Of the 37 multi-year awards made in the 1985-1986 school year, all (100%) were former EFNs. Of the 12 continuation (one-year) awards made, five (42%) were made to former EFNs. The other 7 recipients may also be low-income individuals, but we do not know this information.

Mr. Roybal. What percentage are members of a racial or ethnic minority?

Mr. Kelso. The NHSC Scholarship Program does not collect data on racial and ethnic characteristics or gender.

Mr. Roybal. What percentage are women?

Mr. Kelso. The NHSC Scholarship Program does not collect data on the application form regarding gender. It is only after they come on duty that we know this information. Of the 37 multi-year awards made in FY 1985, 18 (49%) were made to women, and four (33%) of the 12 continuation awards were made to women.

Mr. Roybal. What percentage are themselves from an area which is or was until recently a Health Manpower Shortage Area (HMSA)?

Mr. Kelso. The NHSC Scholarship program does not readily have data on whether each scholarship applicant lives or has lived in a HMSA. Although the criteria used in scoring and ranking scholarship applications include the degree to which an applicant has volunteered. Accordingly, those applicants who received awards tend to be those who have resided or worked in shortage areas because of the weight given to scoring this item.

HEALTH PROFESSIONS

Mr. Roybal. What is the number of persons and the total dollar amount of assistance provided to individuals under HRSA's various Health Professions programs in 1985? What percentage of those individuals are low-income, women, or members of a racial or ethnic minority? What amount of funds and number of individuals is estimated for these programs in 1986 if the rescission is approved, and likewise if the rescission is not approved?

Mr. Kelso. The following table provides the information you requested for those Health Professions programs which provide assistance to individuals. The information for percentage of low income, women, or members of a racial or ethnic minority is not available, except that all recipients of Health Professions Student Loans must meet the definition of exceptional financial need. Effective July 1, 1986, recipients of Nursing Student Loans will be required to meet the definition of exceptional financial need as determined by the Secretary.

HEALTH PROFESSIONS ASSISTANCE FOR INDIVIDUALS

HEALTH PROFESSIONS
($ in thousands)

Program	FY 1985		FY 1986 After Sequestering 1/		FY 1986 Revised Budget 2/	
	Program Amount	Number of Individuals Assisted	Program Amount	Number of Individuals Assisted	Program Amount	Number of Individuals Assisted
Public Health Traineeships........	$3,000	1,509	$2,871	1,444	0	0
Health Admin. Traineeships........	$500	375	$479	358	0	0
Prof. Nurse Traineeships..........	$11,500	4,100	$11,005	4,100	0	0
Nurse Anesthestists Traineeships..	$800	600	$766	574	0	0
Nurse Research Fellowships........	$2,000	165	$1,914	153	$733	68
Except. Finan. Need Scholarships..	$7,000	421	$6,699	391	0	0
Stipends for Disad. Assist. of EFN	(New in FY 1986)		$4,880	488	0	0
HEAL (guaranty limit).............	($271,000) 3/	27,374	($389,000) 4/	39,292	($389,000) 4/	39,292
HP Student Loan Revolving Fund ...	($43,800)	19,600	($49,000)	19,600	($49,000)	19,600
Nursing Student Loan Revol. Fund..	($13,300)	12,971	($18,000)	18,000	($18,000)	18,000

1/ Funding level if the rescission is not approved.
2/ Funding level if the rescission is approved.
3/ Includes $21 million carryover.
4/ Includes $114 million carryover.

Mr. Roybal. What assurances are there that, if all the HRSA health professions programs are eliminated, that the special program emphases--such as orientation toward minority and disadvantaged individuals, primary care and geriatric care--can and will be assumed by individual academic institutions without the Federal assistance?

Mr. Kelso. There can be no absolute assurance in times of fiscal constraints that special program emphases will be assumed by individual academic institutions without Federal assistance. However, Federal support over the past twenty years has built an infrastructure that most likely would enable most of the institutions involved to continue these health professions programs in the future.

Mr. Roybal. What assurances are there that these important efforts can be maintained, especially in light of other cuts those institutions may be facing, such as the reductions in Medicare reimbursement for medical education and the reduction on indirect costs from biomedical research grants?

Mr. Kelso. We feel an infrastructure is available that should enable the institutions involved to continue these health professions programs in the future.

DISADVANTAGED ASSISTANCE

Mr. Roybal. The report from the DHHS Task Force on Black and Minority Health indicates that blacks and other minorities are still underrepresented in the medical professions and in medical schools--in fact, the percentage of blacks has decreased since the mid-70's. Given this situation, how can the Administration justify eliminating the Disadvantaged Assistance Program, rather than strengthening it?

Mr. Kelso. We believe that programs begun by the Disadvantaged Assistance program will be institutionalized by schools and that during times of Federal fiscal constraints non-educational institutions now conducting programs with support from the State and the private sector will continue these programs into the future. In addition, financial student assistance will continue to remain available to Black medical students and other disadvantaged individuals who wish to pursue a health career. Approximately $49 million in FY 1986 and in FY 1987 will be available from the health professions student loan revolving accounts maintained in participating institutions to assist an estimated 19,600 economically needy students each year. Other sources of financial assistance will be available in the Health Education Assistance Loan program and loan programs maintained by the Department of Education.

AREA HEALTH EDUCATION CENTERS (AHEC)

Mr. Roybal. Please provide evidence demonstrating how effective the AHEC program has been over the last 5 years in recruiting and retaining physicians into underserved areas, especially related to any special initiatives in geriatric care and minority recruitment and training.

Mr. Kelso. No national evaluative studies have been done on this issue. Anecdotal information suggests the following with respect to AHEC service areas:

- Black physicians in North Carolina increased 2 1/2 times between 1972-1983, a change of 118 to 295.
- In Maryland, of 160 health professions students, 40 percent have settled in rural areas.
- In North Dakota, 37 Native American doctors have graduated since 1973.
- In South Carolina, Black physicians have increased 272 percent since 1976.
- In Colorado, a 1985 survey shows that 50 percent of graduating medical students reported having a clinical experience in a rural area with 30 percent willing to practice in towns with a population of 50,000 or less.

The AHEC program has sponsored special initiatives with emphasis in geriatric care and minority recruitment. For geriatric care these include: information resources on aging for AHEC libraries; case management training for health professions long-term care; geriatric care initiatives for rural health professions; and geriatric house call curriculum development. For minority recruitment and training, one FY 1985 special initiative was awarded in this area. Also, minority recruitment efforts are performed in most of the regular AHEC projects.

Mr. Roybal. Where are the 14 Area Health Education Centers (AHECs) located which would not receive funding as a result of this rescission?

Mr. Kelso. Thirteen of the 14 AHECs are University of California-San Francisco, College of Osteopathic Medicine of the Pacific, University of Arizona, Southeastern College of Osteopathic Medicine, Morehouse School of Medicine, University of Louisiana, University of New England, Michigan State University, University of New Mexico, Oklahoma College of Osteopathic Medicine and Surgery, Meharry Medical College, Texas Tech University Health Sciences Center School of Medicine, and the University of Washington. The remaining AHEC is a competing project and its location is unknown at this time.

Mr. Roybal. What has/will be the basis for "deselecting" them as part of this rescission request?

Mr. Kelso. The deselecting decision is based on funding anniversary dates. The University of Massachusetts Medical School, University of Cincinnati College of Medicine, and Eastern Virginia Medical Authority have already been funded because their payments fell during the first part of the fiscal year.

Mr. Roybal. Please provide evidence demonstrating how effective the AHEC program has been in recruiting and retaining physicians into underserved areas over the last 5 years.

Mr. Kelso. No national evaluative studies have been done on this issue. Anecdotal information suggests the following with respect to AHEC service areas:

- Black physicians in North Carolina increased 2 1/2 times between 1972-1983, a change of 118 to 295.
- In Maryland, of 160 health professions students, 40 percent have settled in rural areas.
- In North Dakota, 37 Native American doctors have graduated since 1973.
- In South Carolina, Black physicians have increased 272 percent since 1976.
- In Colorado, a 1985 survey shows that 50 percent of graduating medical students reported having a clinical experience in a rural area with 30 percent willing to practice in towns with a population of 50,000 or less.

Mr. Roybal. What special initiatives in geriatric care and minority recruitment and training have been sponsored by the AHECs?

Mr. Kelso. The AHEC program has sponsored special initiatives in geriatric care and minority recruitment. For geriatric care, these include: information resources on aging for AHEC libraries; case management training for health professions long-term care; geriatric care initiatives for rural health professions; and geriatric house call curriculum development.

In FY 1985, 9 geriatrics special initiative projects were funded. With respect to minority recruitment and training, one FY 1985 special initiative was awarded in this area. Also, geriatric and minority recruitment efforts are performed in most of the regular AHEC programs. I will provide the Committee staff with copies of the AHEC Bulletins devoted to minority and geriatric activities.

SPECIAL EDUCATIONAL INITIATIVES: GERIATRIC TRAINING

Mr. Roybal. What is the focus of the geriatric/long term care studies being done under HRSA's special Educational Initiatives?

Mr. Kelso. Geriatric Education Centers are established to facilitate training of medical, osteopathic, dental, optometric, podiatric, nursing, and appropriate allied and public health students and practitioners in the diagnosis, treatment, and prevention of the diseases and other health concerns of the elderly. Functioning within a stated geographic area, a Geriatric Education Center provides comprehensive services to the health professions educational community within that area. All of the centers deal with the education of professionals to deliver services in acute care, long term care, ambulatory and home care settings. The focus of the centers is on preparing faculty to teach geriatrics and develop geriatric programs, as well as technical assistance and consultation and information dissemination in their service areas. Many of the centers also carry out geriatric curriculum development and continuing education for practitioners serving the elderly. All of the centers are multidisciplinary in approach, including medicine and nursing as well as other health professionals.

Mr. Roybal. Please name the institution, the location and project focus for the 16 continuation projects and any of the new projects which focus on long term care all of which have been proposed for rescission?

Mr. Kelso. The following list shows the 16 grantee institutions for Geriatric Education Centers in continuation status in FY 1986. Universities in other States participate through sub-contracts with these Geriatric Education Centers.

University of Puerto Rico
San Juan, Puerto Rico

Hunter College jointly with
Research Foundation of CUNY
New York City, New York

Temple University Insti. of Aging
Philadelphia, Pennsylvania

University of Pennsylvania
Philadelphia, Pennsylvania

Virginia Commonwealth University
Richmond, Virginia

University of Alabama
at Birmingham
Birmingham, Alabama

University of North Carolina
Chapel Hill, North Carolina

University of Mississippi
Medical Center
Jackson, Mississippi

University of Kentucky
Research Foundation
Lexington, Kentucky

Case Western Reserve Univ.
Cleveland, Ohio

Baylor College of Medicine
Houston, Texas

University of Texas Health
Science Center
San Antonio, Texas

Curators of the University
of Missouri
Columbia, Missouri

University of Utah
Salt Lake City, Utah

University of North Dakota
Grand Forks, North Dakota

University of Washington
Seattle, Washington

NURSING PROFESSIONS

Mr.Roybal. Please provide the evidence that, if the Federal government withdraws from the responsibility, the supply of adequately trained nurses in specialty areas, such as geriatrics, can keep pace with the increasing need precipitated by demographic changes and the changing need dictated by advances in medicine and nursing practice?

Mr. Kelso. We anticipate that market forces will induce nurses to seek training in the specialty areas needed.

Mr. Roybal. What proportion of the existing nursing research grants and nursing special projects deal with care of Alzheimer's patients or the elderly?

Mr. Kelso. Approximately 10% of the nursing research grants deal with the care of the elderly. No currently supported nursing research grants deal with the care of Alzheimer's patients. Of the currently supported nursing special project grants, 8% deal with care of the elderly. None specifically address care of Alzheimer's patients.

HEALTH MAINTENANCE ORGANIZATIONS

Mr. Roybal. How did you arrive at the estimate of $10 million in user fees for HMO qualification review and Competitive Medical Plan determination?

Mr. Kelso. The estimates are based on projections of qualification applications from new HMOs, requests for Competitive Medical Plan (CMP) eligibility determinations and estimates of the federal costs for these review activities. The fee is initially proposed to be $40,000 for new HMOs and Regional components and $20,000 for service area expansions. The CMP user fee is proposed to be $25,000.

Mr. Roybal. What impact will that have on smaller health care organizations who might apply for qualification?

Mr. Kelso. Since even small organizations require adequate capitalization to handle deficits until financial breakeven is achieved, it is unlikely that the charge for qualification or eligibility determination would impose a significant barrier to entering the CMP or HMO business.

Mr. Roybal. How does the estimated number of organizations seeking HMO qualification or CMP determination compare with previous years? Given the planned cuts in FTEs in the Bureau of Health Maintenance Organizations and Resource Development, are there adequate resources in the Office of Health Maintenance Organizations to complete the reviews in a timely fashion and with adequate attention to both quality and cost issues?

Mr. Kelso. During FY 1985, the number of HMOs qualified (48 new HMOs and 47 Regional components) exceeded the total number qualified during FY 1982 - 1984 combined. Projections for FY 1986 show the FY 1985 increased application trend continuing, with total new applications anticipated to equal the number received in FY 1985. We expect the trend will continue in the next two fiscal years. CMP eligibility determination actions are more recent. Thirty-three applications have been received since final regulations were published in January 1985. We expect the number of applications to increase in this and the next fiscal years.

Mr. Roybal. Are there sufficient resources to maintain the ongoing monitoring of HMOs and CMP?

Mr. Kelso. The FTE reductions in the budget request are associated with the termination of the health planning program. The resources available for HMO/CMP activities have been adequate for reviews in a reasonable amount of time without adversely affecting quality or cost. If the increased application trend continues, as we think it will, the agency will review the resource needs.

MCH BLOCK GRANT AND SET-ASIDE

Mr. Early. In FY 1986 under the Gramm-Rudman reduction, funds available for maternal and child health block grants will decline from $406.3 million to $388.8 million. Can you give us some idea of what impact this will have on programs and services at the state level?

Mr. Kelso. Because the maternal and child health block grant authority provides States with maximum flexibility in how they utilize these resources and does not require that States report uniformly on what services are provided, it is impossible to predict what impact the reduction will have on services. States will take differing approaches to the reduction in funds and it is unclear what direct effect this reduction will have. In some instances, States may provide funds from other sources to offset the decrease, in some they may transfer funds from other block grants, and in others they may find a way to decrease administrative overhead costs to avoid decreasing services. We have no way of predicting the net effect.

Mr. Early. Not too long ago, my state of Massachusetts put together a task force to examine the problem of infant mortality and low-birth weight babies and developed a series of recommendations/ proposals to address this problem. Are you familiar with this task force report, and, if so, would you comment on it?

Mr. Kelso. We are familiar with the recent Massachusetts Low Birth Rate and Infant Mortality Task Force Report. This report, "Closing the Gaps: Strategies for Improving the Health of Massachusetts Infants," describes the progress made in reducing the rates of infant mortality, delineates regional variation in low birth weight and infant mortality rates and identifies discrepancies in the available resources and services. This report identifies gaps between different high risk groups and contains recommendations for State programs to close the gaps.

We are supportive of the findings and the Commonwealth's efforts to improve health status and services for their infants. In addition to Maternal and Child Health Block grant support, the Division of Maternal and Child Health is currently funding an Improved Prenatal Care Utilization and Birth Outcome Project. Specifically, this project will identify the behavioral, cultural and structural factors that influence prenatal care utilization. This information will be used in the development and implementation of multi-facted community based interventions in the following four sites: selected Boston neighborhoods - Roxbury, Mattapan, the South End -, the South Berkshires, New Bedford and Holyoke/Chicopee.

The impact of these interventions on prenatal care utilization and birth outcomes will be evaluated. Information about the projects will be disseminated on a local, regional and national basis.

Mr. Early. The budget justification indicates that $68.6 million, $3.1 million less than the FY 1986 enacted level, will be available for the MCH set-aside program. How many fewer projects will be supported under the revised amount as compared to the enacted level? How, and in what areas, will this reduction be made?

Mr. Kelso. Approximately eighteen projects will not be funded in 1986 as a result of the $3.1 million reduction in the set-aside program. These will not be specific defunding of projects, but constitute an estimate of the number of new projects which might have been funded had the additional dollars been available. We do not anticipate that the 4.3 percent reduction which the $3.1 million represents will have a serious impact on our ability to support a wide range of projects in all five of the categories in the set-aside. We will support a total of 384 projects with the $68.6 million available - 43 in research, 117 in training, 26 in hemophilia diagnosis and treatment, 49 in genetics, and 149 in maternal and child health improvement, with special emphasis on infant mortality, low birthweight and the improvement of services for the disabled and chronically ill infants and children.

Mr. Early. What types of projects are you planning to support in FY 1986 and FY 1987 in the SPRANS category designated "Other"?

Mr. Kelso. "Other" projects in the SPRANS set-aside will deal with improvements in maternal and child health, with special emphasis on infant mortality, low birthweight and the improvement of services for the disabled and chronically ill infants and children. An estimated 149 projects will be supported in FY 1986 and 156 in FY 1987.

Mr.Early. Would you bring us up-to-date on the bureau's activities concerning the AIDS problem?

Mr. Kelso. The Bureau of Health Care Delivery and Assistance (BHCDA) is participating in the overall PHS effort and serves on various committees and task forces responsible for advising on specific AIDS programs.

Within the framework of the programs for which it is responsible, BHCDA is participating in the information and education activities of PHS and is disseminating information to primary care projects supported by BHCDA grants.

The work of the Hemophiliac Foundation is supported in BHCDA. Through the Hemophiliac Information Exchange, a means for providing accurate and current information about hemophilia and AIDS to providers and consumers has been established. Workshops dealing with psychosocial needs of patient's families and providers under the leadership of the National Hemophilia Foundation are being carried out in each of the ten regions of the country. A study has been undertaken to assess the impact of AIDS on the utilization of blood products. Studies are underway to measure the impact of DRGs on hemophilia care. These studies will include both the medical and psychosocial implications of AIDS.

Concerning the problem of pediatric AIDS, the PHS sponsored a conference which focused on diagnosis and treatment, as well as access to day care, education and other children's services. The PHS guidelines and recommendations have been issued regarding the education, foster care, and perinatal transmission of the HLTV-III virus. Local communities have begun to implement these recommendations.

Mr. Early. Do you have any collaborative efforts underway with the Center for Disease Control (CDC)? To what extent do you coordinate activities/plans in this area with CDC?

Mr. Kelso. The BHCDA's Division of Maternal and Child Health (DMCH) has participated in multi-agency activities coordinated by CDC which were directed to the development of guidance on the handling of children affected with AIDS, particularly concerning their participation in school activities, as well as the guidelines for prevention of perinatal transmission. Similarly, CDC representatives have principal participants in National Conferences which DMCH has sponsored to make assessments of the nature and scope of the AIDS problem in relationship to mothers, infants and children. Currently, CDC, DMCH and the National Hemophilia Association are developing an approach to the distribution of recently appropriated funds to be used in development of risk reduction efforts -including psychosocial support- for hemophilia patients who have contracted AIDS.

The National Hemophilia Foundation's Information Exchange is used extensively by CDC as one means of disseminating statistical information and guidance materials to the professional community and to hemophilia patients.

Mr. Early. Tell us about "Project Zero to Three" which is being funded by the Division of Maternal and Child Health (MCH). What are the objectives of this program?

Mr. Kelso. "Project Zero to Three," is the title of a project funded under the MCH Special Projects of Regional and National Significance (SPRANS) authority. The grant, awarded to the National Center for Clinical Infant Programs, Washington, D.C., provides a mechanism for States to share information and experience. Ten States have participated over the past two years, including Maine, New Jersey, Maryland, North Carolina, Ohio, Texas, Iowa, Utah, Hawaii and Washington. Five additional States recently joined the Project Zero to Three network: Massachusetts, New York, Florida, Kansas and Oregon.

The goals of the project are to:

o present new clinical and research knowledge that can help inform State programming;

o increase recognition of the interrelatedness of physical, cognitive, social and emotional development and the importance of this relationship in preventing and ameliorating disabling conditions;

o promote interagency collaboration as a means of fostering comprehensive and coordinated services, relevant research, and appropriate training of needed personnel;

- promote appropriate and extended use of parents as resources for their children, for other disabled and at-risk infants, toddlers and their families, and for the service system.
- help States to identify their technical assistance, consultation and networking needs and take appropriate steps toward meeting these needs.
- facilitate within-and between-State networking by offering approaches toward meeting these needs;
- ensure that health concerns are addressed in the earliest years by fostering the leadership role of the MCH-CC agency in project States;
- expand project influence to all 50 States for the purpose of advancing services for disabled and at-risk children nationally, enhancing the leadership role of project States within their regions as appropriate;
- identify national needs for multidisciplinary training, knowledge transfer and networking and provide opportunities for addressing those needs.

Each December, the Project's Core Advisory Panel and representatives from Project States attend a national meeting to review their successful experiences that might be of use to others. In addition, a series of small invitational meetings have provided an opportunity for several States to exchange expertise or to work toward a consensus of experts about the "state of the art" in a given area: Issues examined in these meetings have included:

-- The advantages and disadvantages of mandating services to disabled and at-risk children from birth to three onward and policy alternatives to such legislation. There Ought to Be a Law? published in April 1985 is based on that meeting.

-- Refining the parameters of State and community systems for tracking children identified as at risk or handicap or developmental delay. Keeping Track, published in August 1985, comes from that meeting.

--The specific criteria which should be used in deciding whether to enter an infant or toddler into a tracking system. the report of this meeting of experts in the field will be published in late 1985 or early 1986.

--How States and the services they fund and monitor can best conduct program evaluation in order to make their own work more effective. The report on evaluating programs was published in late 1985.

Changes are needed to improve both preservice and inservice training for early intervention services.

HEALTH PROFESSIONS PROGRAMS

Mr. Early. In addition to direct appropriations, the President's budget also proposes a reduction in health education loans and a reduction in Medicare payments related to medical education. If adopted, what effect would these changes have on medical education? What effect would these reductions have on medical education programs? Where would funds come from to replace lost Federal support?

Mr. Kelso. It is unlikely, if costs of medical education are reduced, that lost Federal support will need to be replaced. Besides, the maket forces are beginning to demonstrate favorable impact on the health care delivery system. In addition, students seeking to enter health professions careers will be able to secure loans from the $49 million Health Professions Student Loan revolving fund as well as $100 million in Health Education Assistance Loans, and Guaranteed Student Loan and other Department of Education loan programs. Students may also qualify for State, private and institutional loan and scholarship programs.

At this time, the effects of these changes are somewhat uncertain. The financing and delivery of health services in the U.S., both (a) the proposed limitation on direct medical education reimbursemnet and (b) the elimination of the doubling of the indirect medical education adjustment rate, are intended to provide adequate incentives for providers to hold down the costs of medical education. It is not expected that these changes will be injurious to medical education programs. The administration feels that other Federal, State, and private programs combined with the health education loans will provide adequate student assistance funding.

Mr. Early. The budget proposes rescinding the balance of funds available after sequestration for the NHSC scholarship program and for several traineeship programs (public health, health administration, nursing). Will any students who have previously received commitments for assistance or who have received multi-year awards lose their assistance under these rescission proposals?

Mr. Kelso. Health Professions and nursing average between two and three years of support to students to complete their educational training. If the proposed rescission is approved, approximately 3,000 persons who are in training would not be financially assisted by these programs.

Mr. Early. For the record, please provide a table displaying, for each scholarship, fellowship, and traineeship program, the number of awards that could have been made under the FY 1986 enacted appropriation levels, as well as the average award size.

Mr. Kelso. For the record the following table is provided:

BUREAU OF HEALTH PROFESSIONS

FY 1986 Enacted Appropriation Estimated Number of Student Awards, and Average Amount per Student for Scholarship, Fellowship, and Traineeship Programs

Program	FY 1986 Appropriation ($000)	Estimated Number of Student Awards	Average Amount Per Student
Exceptional Financial Need Scholarships..............	$7,000	409	$17,111
Stipends for Disadvantaged Students of Exceptional Financial Need.................	$5,100	510	$10,000
Public Health Traineeships......	$3,000	1,696	$1,988
Health Administration Traineeships...................	$500	375	$1,333
Professional Nurse Traineeships.	$11,500	4,200	$2,756
Nurse Anesthetist Traineeships...................	$800	600	$1,333
Nurse Research Fellowships......	$2,000	164	$8,300 * $19,000 to $24,700 **

* Average for Predoctoral Students
** Average for Postdoctoral Students

Mr. Early. For FY 1986, the Administration is proposing to rescind $12.483 million of the $17.226 million available for the AHEC program after sequestration. What impact will this substantial reduction in funding have on existing AHEC projects?

Mr. Kelso. The precise impact is unknown. However, there will be a termination of six projects in the planning stage, six in the developmental stage, and one in the operational stage.

Mr. Early. Will any AHEC projects be "graduating" from the program by the end of FY 1986? What about FY 1987?

Mr. Kelso. No projects will be graduating in either FY 1986 or FY 1987, however 4 projects will be in their last year of Federal support in FY 1987.

Mr. Early. What additional funds would be needed in FY 1987 to fund continuation projects at the approved award rates? To support the new AHEC projects initially envisioned for FY 1986?

Mr. Kelso. Approximately $16.3 million will be needed in FY 1987 to fund continuation projects at the approved award rates.

Mr. Early. For the record, please summarize the kinds of projects that are supported with AHEC special initiative funds.

Mr. Kelso. The kinds of projects supported by special initiative funds are as follows:

- Geriatrics training for rural health professionals;
- Geriatrics house call curriculum development;
- Minority recruitment and training;
- Information resources on aging for AHEC libraries;
- Case management training for health professions long-term care;
- Computer-simulation training; and
- Health promotion and disease prevention

Mr. Early. How will you make the reductions, required under the March 1 sequestration order, in the general internal medicine and pediatrics residency program, and what effect will the reduction have on these activities?

Mr. Kelso. A 4.3 percent reduction has been made in the general internal medicine and general pediatric residency program as in all the appropriated authorities under Title VII. As a result of the FY 1986 sequestration order, approximately 2 fewer competitive grants will be made in the general internal medicine and pediatric residency program.

Mr. Early. Please provide the same information for the family medicine residency training program.

Mr. Kelso. As a result of the FY 1986 sequestration order, approximately 14 fewer competitive graduate grants would be made in the family medicine residency program.

Mr. Early. Of the projects that could be supported in FY 1986 after sequestration, how many would be in non-competing continuation status in FY 1986 and how many would be competing renewals for general internal medicine? Family medicine?

What amount is needed in FY 1986 to fund these non-competing continuations at the approved rate?

Mr. Kelso. The following listing provides the information you requested on primary care residency and training programs:

	Number of Noncompeting Continuations in FY 1986	Number of Competing Renewals in FY 1986 1/	Est. Amount Needed in FY 1986 for Noncompeting Continuations	Estimated Amount Needed in FY 1986 to Fund Renewals 1/
Family Medicine Graduate	76	63	$7,800,000	$8,530,000
Family Medicine Faculty Development	46	0	$6,500,000	0
Family Medicine Predoctoral	32	16	$4,200,000	$1,875,000
Family Medicine Departments	21	46	$1,800,000	$5,132,000
General Internal Medicine/General Pediatrics Residency	82	3	$15,900,000	$544,000
General Internal Medicine/General Pediatric Faculty Development	8	0	$800,000	$100,000
TOTALS	265	128	$37,000,000	$16,181,000

1/ Does not include projects and dollars for new awards.

Mr. Early. Please provide for the record the information requested below for the following programs: general medicine residencies, family medicine residencies, family medicine departments, and preventive medicine residencies.

Of the projects that would be supported at the post sequestration level, how many would be in non-competing continuation status in FY 1987, and how many would be up as competing renewals?

What amount is needed to fund these non-competing continuations at the approved rate?

How much more would be needed to fund all programs up for renewal at the estimated FY 1986 award rate?

Mr. Kelso. The following listing provides the information you requested on Health Professions residency and training programs:

	Number of Noncompeting Continuations in FY 1987	Number of Competing Renewals in FY 1987 1/	Est. Amount Needed in FY 1987 for Noncompeting Continuations	Estimated Amount Needed in FY 1987 to Fund Renewals 1/
Family Medicine Graduate	135	43	$15,555,000	$4,014,000
Family Medicine Faculty Development	25	21	$3,531,000	$2,689,000
Family Medicine Predoctoral	21	32	$3,271,000	$3,627,000
Family Medicine Departments	67	8	$6,360,000	$537,000
General Internal Medicine/General Pediatrics Residency	87	48	$7,596,000	$9,244,000
General Internal Medicine/General Pediatric Faculty Development	9	0	$904,000	0
TOTALS	357	152	$38,807,000	$20,111,000

1/ Does not include projects and dollars for new awards.

HEALTH EDUCATION ASSISTANCE LOANS

Mr. Early. Why is there a $114 million carryover of loan guarantee authority into FY 1986?

Mr. Kelso. The $114 million HEAL insurance authority carried into FY 1986 represents unused insurance authority from years prior to FY 1986.

Mr. Early. After considering carryover balances, how much in loans do you expect to guarantee in FY 1986?

Mr. Kelso. We expect to insure $389 million in HEAL loans in FY 1986.

Mr. Early. The budget request includes appropriation bill language to allow lenders to charge borrowers life insurance fees on unpaid balances of guaranteed loans. Why is the language necessary?

Mr. Kelso. We are proposing that lenders assume the risk of loss resulting from the death or permanent and total disability of

HEAL borrowers. The proposal would allow lenders to charge a credit life insurance fee to borrowers to cover this cost. We believe this to be one of the appropriate mechanisms to contribute to the continued solvency of the Student Loan Insurance Fund.

Mr. Early. What would be the cost to the borrowers under this proposal?

Mr. Kelso. We anticipate that the cost to borrowers would be minimal. As an example, on a $10,000 loan repaid over 48 months the Public Health Service Credit Union charges $3.18 per month additional for credit life insurance and a one time charge of $14.75 for disability insurance. This cost is very low since borrowers of HEAL funds are young and insurance costs minimal.

Mr. Early. You are also proposing to have lenders assume 20% of the loss resulting from default by the borrowers or any HEAL loan: Why is this necessary?

Mr. Kelso. We strongly believe that HEAL lenders will be more diligent in monitoring borrowers and collecting repayments if they assume some risk if the borrowers default on their payments. This will contribute significantly to the continued solvency of the Student Loan Insurance Fund.

Mr. Early. Do you think these two proposals will discourage lender participation in the program? What, if any, feedback have you had on these proposals from lenders?

Mr. Kelso. A study conducted by the Department's Inspector General in September 1985 indicates that at 20% risk sharing over half of the current participating banks would probably discontinue participation in the HEAL program. The remaining banks would offset their potential liability by tightening loan criteria and reducing total loan volume. We have no lender feedback concerning the charging of an insurance premium to cover claims resulting from death and disability.

FEDERAL EMPLOYEE OCCUPATIONAL HEALTH

Mr. Hoyer. Mr. Kelso, the last several years the House and Senate Subcommittees have been very interested in your Administration's plans for the FEOH program. As you noted in your justification both Subcommittees included language in the Report on this subject.

The Senate Report directed your office to provide a detailed study of the program by this month. It further provides that there should be no reduction in staff or services until receipt of the report.

The House Report specifies a minimum level of operations of $15,750,000, the FY 1985 level. This action was taken as an interim measure in FY 1986 pending submission of a plan which maintains services and protects the rights of career employees.

Have either of these two reports been completed?

Mr. Kelso. Yes. The Bureau has submitted the reports to the HRSA for review and comment before being forwarded to the Congresss.

Mr. Hoyer. If not, when? If so, what are their major findings?

Mr. Kelso. By the end of FY 1989, the staff would be reduced by approximately 156 to 206 full-time employees without a reduction-in-force (RIF) or disruption in services, and the program would be able to reach its objective of a regionalized consulting staff serving as the occupational health advisor to management and managing the delivery of direct services, if requested.

Mr. Hoyer. On page 12 of your justification you show a decrease of 78 FTE(s) in this program. Are you anticipating that we will accept your recommendation?

Mr. Kelso. Yes, we are anticipating that Congress will accept the President's recommendation.

Mr. Hoyer. Are you going to wait until Congress acts before you begin any adverse employee actions?

Mr. Kelso. Yes, we will wait for Congress to act.

FULL-TIME EMPLOYEES

Mr. Hoyer. While I am on the subject of Federal employees your justification on page 20 shows a decline in full-time permanent positions from 2,892 in 1986 to 2,003 in 1987, a decrease of 889. The decrease is more substantial when compared with 1985 (3,015). There's a loss of more than 1,000 positions. At the same time you show an increase in "full-time equivalent of all other positions" from 327 in 1985 to 152 in 1986 to 236 in 1987. What explains the dramatic decrease in the permanent position category?

Mr. Kelso. The reduction in the 1987 proposed FTE level is due to the primary health care categorical programs being consolidated into the proposed expanded primary care block grant, the elimination of the health professions and health planning activities within HRSA, and the service and supply FTE level of 168 being inadvertently included in FY 1985.

Mr. Hoyer. Why is there such fluctuation in the second category?

Mr. Kelso. The reduction of FTEs from FY 1985 to FY 1986, in other than full-time permanent positions, was due to a reduced FTE ceiling set within the bureau in FY 1986 but has been adjusted in FY 1987.

Mr. Hoyer. Do you intend any RIFs or furloughs this year?

Mr. Kelso. The HRSA does not intend to have a RIF or furlough this year because of the controls that were imposed on discretionary administrative spending.

Mr. Hoyer. How have these employees been separated from HRSA?

Mr. Kelso. Since HRSA has been in existence, a RIF or furlough has not occurred. Any employee that was separated from HRSA, up to the present time, was discharged on a voluntary separation, such as retirement, resignation, or transfer to another agency or department.

HEALTH PROFESSIONS

Mr. Hoyer. Mr.Kelso, I think we all can agree, particularly lawyers, that there's an oversupply of doctors nationally.

At the same time, however, most experts agree that at the same time there are shortages in certain areas, i.e., minority doctors, family/general practice physicians, podiatrists, etc.

Your proposal before seems to cut a wide swarth through all the health professions training funds regardless of the recognized need in some specific areas.

Can one assume from your justification that you have decided to look the other way? If not, how will we as a nation address these shortages?

Mr. Kelso. Federal efforts in support of health professions programs have provided a considerable investment during the last two decades in increasing the supply of health professionals. We have observed that there is a growing number of educational institutions that maintain these programs without Federal assistance. In addition, State Governments and the private sector are also raising their level of involvement in educational institutions. We look to these non-Federal sources as the means to address these important objectives.

Mr. Hoyer. How can we increase the supply of minority physicians without the financial assistance provided by programs that you propose to eliminate?

Mr. Kelso. Federal efforts in support of health professions programs have provided a considerable investment during the last two decades in increasing the supply of health professionals. We have observed that there is a growing number of educational institutions that maintain these programs without Federal assistance. In addition, State Governments and the private sector should also raise their level of involvement in educational institutions. We look to these non-Federal sources as the means to address this objective.

NURSE ISSUES

Mr. Hoyer. While I am on the subject of shortages in the health professions, several recent reports have shown the need for an increased supply of nurses with graduate preparation to serve as researchers and specialists in underserved and underprivileged populations. What is the Administration's rationale for requesting severe rescissions and elimination of nursing research and education programs for FY 1987?

Mr. Kelso. Federal support over the past twenty years has substantially increased the capability of schools of nursing to add to the nurse supply. Baccalaureate programs are now firmly established in academic settings and have available to them similar resources as for other health disciplines.

Mr. Hoyer. Your Administration has also argued continually that there is an oversupply of nurses. From all that I have seen and heard this is incorrect. What studies or information do you have that would support your rationale?

Mr.Kelso. Evidence presented in the Fifth Report to the President and the Congress on the Status of Health Personnel in the U.S. found no aggregate imbalance between supply and requirements in the foreseeable future. Changes in the health care delivery system could alter the supply-demand equation, but there is no quantifiable evidence to date to document the impact of such changes.

Mr. Hoyer. Mr.Kelso, what efforts have been made by HRSA to facilitate the transfer of the nursing research activities from the Division of Nursing to the NIH?

Mr. Kelso. Senior HRSA staff have been actively meeting with NIH regarding the transfer of nursing research activities. An implementation plan for relocation of these functions has been received in the Department and negotiations are underway between HRSA and NIH regarding transfer of staff, extramural funds and direct operating funds.

Mr. Hoyer. When do you expect the transfer to take place?

Mr. Kelso. A specific date for the transfer to take place has not been set. We have recently learned that space has been found at NIH to house the Center.

Mr. Hoyer. Has any of the $5 million appropriated by Congress in P.L. 99-88 become available for use by HRSA?

Mr. Kelso. No, it has not. Public Law 99-88 restricts use of these funds to NIH. These funds are currently proposed for rescission.

MATERNAL AND CHILD HEALTH

Mr. Hoyer. We are all aware that post neonatal mortality is increasing by 3 to 6 percent per year; that the nation's decline in overall infant mortality has slowed; that low birth weight and prematurity are on the rise and that prenatal care patterns are worsening.

First, how many people would you estimate are going unserved or underserved?

Mr. Kelso. The latest statistics on served and unserved populations are for 1983 and are provided by the National Center for Health Statistics. In that year 57,849 women or 1.6% of those who had live births got no prenatal care. Women who registered for prenatal care in the third trimester numbered 140,460, representing 3.9% of those who had live births. Third trimester care is considered inadequate. An additional 650,600 women registered in the second trimester. This represents 18.2% of the women delivering live births. Second trimester care is not definitively considered inadequate but can adversely affect birth outcomes.

Mr. Hoyer. Is there a need to increase the authorization for the Maternal and Child Health Block Grant? If not, why?

Mr. Kelso. There is clearly a need for expanded care for high risk mothers and infants. The Maternal and Child Health Block Grant represents one source of funding for such care and it has increased from the previous categorical funding level of $363 million to $406 million proposed for 1987. The block grant is designed to afford States the flexibility to apply resources according to their priority needs for services for mothers and children and handicapped individuals. Given the current need for budget restraint, it is felt that the current authorization level of $478 million is adequate. This level provides $406 million for the block grant to States and $72 million for discretionary grants under the authority of the 15% set-aside.

Mr. Hoyer. How will the 15% set-aside be used in FY 1987 to attack some of these problems and how was it used in FY 1986?

Mr. Kelso. In 1986 and 1987 the problems associated with infant mortality rates and the incidence of low birthweight infants continue to be of the highest priority in the Department which has in place a major initiative supported by funds from the 15% set-aside. In 1985 we funded 15 new projects to States and localities with large underserved populations or with high infant mortality or morbidity rates. These new Effective Pregnancy and Infant Care (EPIC) projects are designed to identify gaps in the maternal and child health care system and propose methods to correct them. In 1986, in addition to continuing these 15 projects, we will fund about 10 more EPIC projects. Also, under the research and training activities in the set-aside funding, we are addressing the need for identification of improved methods of providing care to high risk mothers and infants and to increasing the number of skilled professional health care providers with expertise in prenatal, neonatal and postnatal care.

NURSING RESEARCH

Mr. Pursell. What efforts have been made by HRSA to facilitate the transfer of the nursing research activities from the Division of Nursing to the N-I-H?

Mr. Kelso. The HRSA staff have been actively meeting with NIH regarding the transfer of the nursing research activities. An implementation plan for relocation of these functions has been received in the Department and negotiations are underway between HRSA and NIH regarding transfer of staff, extramural funds and direct operating funds. We have learned recently that space has been found at NIH to house the staff of the Center. Until the transfer is complete, HRSA is continuing to administer the extramural program supporting nursing research and research training including expenditures for salaries, space, equipment, and overhead costs.

NURSING SUPPLY

Mr. Pursell. In light of several reports showing the need for an increased supply of nurses with graduate preparation to serve as researchers and specialists in underserved and underprivileged populations, what is the Administration's rationale for asking for severe rescissions from the FY 1986 appropriation and elimination of the nursing research and education programs for FY 1987?

Mr. Kelso. Federal support over the past twenty years has substantially increased the capability of schools of nursing to add to the nurse supply. Baccalaureate programs are now firmly established in academic settings and have available to them the same resources as are used for other health disciplines.

Mr. Pursell. What is the Administration's rationale for continually applying the oversupply argument that is correctly used in describing the physician supply/demand ratio to the nursing profession where the argument is incorrect/

Mr. Kelso. Evidence presented in the Fifth Report to the Congress on the Status of Health Personnel in the U.S. found no aggregate imbalance between the nurse supply and requirements in the foreseeable future. Federal support over the past twenty years has substantially increased the capability of schools of nursing to add to the nurse supply. Profound changes in the health care delivery system could alter the supply-demand equation, but there is no quantifiable evidence to date to document the impact of such changes.

Mr. Pursell. A 1983 Institute of Medicine (IOM) report concluded that nurses with high-quality graduate education are a scarce resource. The report recommended an increase in the number of nurses with skills commensurate with "the growing complexity of care in many health settings." The Administration contends that there is an adequate supply of registered nurses in the country. The nursing education monies are not targeted to increasing the number of general nurses. However, they are targeted to preparing nurses at the masters and doctoral levels. There is clearly not an adequate supply of nurses prepared at the advanced levels such as nurse midwives, nurse practitioners, nurse anesthetists, nurse researchers and clinical nurse specialists in geriatrics. How can the Administration ignore the IOM recommendations and propose elimination of Federal funding for advanced nursing education programs?

Mr. Kelso. Individuals undertaking advanced nurse education have an earning capacity and, during times of Federal fiscal constraints, can be expected to finance their further education and seek support from other Federal and non-Federal sources.

Mr. Pursell. In the 1984 fourth report to the Congress on the status of health personnel, the Department of Health and Human Services recommended continued Federal support for nursing education programs, in the words of the report, "to assist in filling the unmet needs for nurses prepared as teachers, administrators, or clinical specialists." How can the Department reverse its position on this issue by allowing the Administration's 1987 budget to eliminate Federal funding for nursing education programs?

Mr. Kelso. The Administration must always reevaluate competing priorities for Federal support. In view of the past Federal investment in advanced nurse education training, we believe that these programs have been institutionalized into the nursing educational system and will be available for those individuals desiring to become teachers, administrators or clinical experts.

Mr. Pursell. On August 16th, 1985, President Reagan signed a three-year authorization of funding under the nurse education act. How can the President now propose complete elimination of those same nursing education programs?

Mr. Kelso. In its reevaluation of competing priorities, the Administration was mindful that twenty years of Federal support had built and stabilized an infrastructure that should enable the institutions to continue these programs into the future. We believe it is now the responsibility of the private sector to maintain the necessary level of support.

Mr. Pursell. Congress authorized and appropriated monies for new nursing demonstration projects to address concerns about access to nursing services. Has this program been implemented yet?

Mr. Kelso. The program has not been implemented, pending the outcome of the proposed rescission.

FISCAL YEAR 1987

Volume I

Justification of Appropriation Estimates for Committee on Appropriations

Health Resources and Services Administration

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH RESOURCES AND SERVICES ADMINISTRATION

Health Resources and Services

Fiscal Year 1987 Budget

Page No.

Appropriation language and Explanation of language changes 3

Language analysis 8

Amounts available for obligation 10

Summary of changes 11

Budget authority by activity 15

Budget authority by object 20

Significant items in the House and Senate Appropriations Committee Reports 22

Authorizing legislation 31

Table of estimates and appropriations 35

Justification:
1. Narrative 36
   A. General Statement 37
   B. Program Accomplishments 39
   C. Activities:
      a. Health care delivery and assistance 45
         1. Maternal and child health block grant 46
         2. Primary care block grant 48
         3. Home health 53
         4. National health service corps 54
         5. National health service corps scholarships 61
         6. National hansen's disease center 64
         7. Federal employee occupational health 66
         8. Payment to Hawaii 68
         9. Direct operations 69

BEST COPY AVAILABLE

b. Health professions............................ 72
  1. Health professions student assistance...... 73
  2. Health professions institutional assistance 76
  3. Health promotion/disease prevention........ 79
  4. Primary care............................... 85
  5. Health professions special education initiatives.................................. 94
  6. Area health education centers.............. 96
  7. Disadvantaged assistance................... 98
  8. Health professions analytical studies and reports.................................... 101
  9. Nurse education............................ 103
  10. Direct operations......................... 114

c. Health maintenance organizations and resources development............................... 116
  1. Local planning............................. 117
  2. State planning............................. 118
  3. Planning methods development............... 119
  4. Outpatient facilities construction......... 120
  5. Health teaching facilities................. 121
  6. Direct operations.......................... 122

d. Buildings and facilities...................... 125

e. Office of the administrator................... 126

2. State tables...................................... 128

3. Estimates for consulting services................. 134

4. Estimates for related services.................... 137

5. Detail of permanent positions..................... 139

TITLE II - DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH RESOURCES AND SERVICES ADMINISTRATION

HEALTH RESOURCES AND SERVICES

Program Operations

For carrying out titles III [, IV, VII, VIII, XV, XVI,] 1/ XIX and XXI of the Public Health Service Act, *and the monitoring of loan collections and the payment of interest subsidies of previously committed loans under titles VII, VIII, XIII, and XVI of said Act* 2/ [section 427(a) of the Federal Coal Mine Health and Safety Act,] 3/ and Title V of the Social Security Act, [$1,360,434,000] *$1,162,870,000*, [of which $500,000 shall be available for assistance to two year schools of medicine or osteopathy under section 788(a) of the Public Health Service Act; of which $2,600,000 shall be available for grants under section 371 of the Public Health Service Act; of which $5,000,000 shall be for construction of and equipment for outpatient medical facilities under section 1610(b),] 4/ of which [$3,300,000] *$2,500,000* shall be available only for payments to the State of Hawaii for care and treatment of persons afflicted with Hansen's Disease; [of which $750,000 to be available until expended, shall be used to renovate the National Hansen's Disease Center; of which $5,000,000 shall be to establish geriatric educational units under section 788(b) of the Public Health Service Act; and of which $1,200,000 shall remain available until expended for interest subsidies of loan guarantees made prior to fiscal year 1981 under Part B of title VII of the Public Health Service Act:] 5/ *of which not to exceed $750,000 shall be available for renovating the Gillis W. Long Hansen's Disease Center, 42 U.S.C. 247e, as amended by P.L. 99-117;* 6/ *and of which not to exceed $190,100,000 shall be available for primary care services to be distributed among the States in the same proportion as funds were distributed in fiscal year 1986 under sections*

229 and 1001 of the Public Health Service Act and section 427(a) of the Federal Coal Mine Health and Safety Act: 7/ *Provided further, That not to exceed $10,000,000 derived in accordance with 31 U.S.C. 9701, is to be credited to this appropriation.* 8/

Administrative Provisions

[*Provided*, That this] *This* appropriation shall be available for payment of the costs of medical care, related expenses, and burial expenses hereafter incurred by or on behalf of any person who has participated in the study of untreated syphilis initiated in Tuskegee, Alabama, in 1932, in such amounts and subject to such terms and conditions as prescribed by the Secretary of Health and Human Services and for payment, in such amounts and subject to such terms and conditions, of such costs and expenses hereafter incurred by or on behalf of such person's wife or offspring determined by the Secretary to have suffered injury or disease from syphilis contracted from such person: *Provided*, That when the Department of Health and Human Services administers or operates an employee health program for any Federal department or agency, payment for the full estimated cost shall be made by way of reimbursement or in advances to this appropriation: *Provided further*, That none of the funds made available by this Act shall be used to provide special retention pay (bonuses) under paragraph (4) of 37 U.S.C. 302(a) to any regular or reserve officer of the Public Health Service for any period during which the officer is providing obligated service under section 338B (or under former sections 225(e) or 752) of the Public Health Service Act except that this proviso shall not apply to any period of service covered by an agreement entered into by an officer under 37 U.S.C. 302(c)(1) before the date of enactment of Public Law 97-377: [*Provided further*, That in addition to the amounts provided herein, $15,750,000 shall be available to the Health Resources and Services Administration from reimbursements from other Federal Agencies and Departments for the operation of employee occupational health programs under 5 U.S.C. 7901: *Provided further,* That no funds appropriated to carry out the Public Health Service Act may be used to award grants to, enter into new contracts or cooperative agreements with, or otherwise assist, a State, or any agency thereof, to administer, or monitor the operation of, or operate (except as provided in section 329(h)(2) and 330(g)(3) any program supported under section 329 or 330, or title XIX-C, of the Public health Service Act:] 9/

Direct Loans and Loan Guarantees

[*Provided further,* That during] *During* fiscal year [1986] *1987,* the Secretary of Health and Human Services shall enter into commitments [to guarantee loans,] *totalling $100,000,000 to guarantee up to 80 per centum of the value of Health Education Assistance Loans under subpart I of Part C of title VII of the Public Health Service Act,* [to students who have not previously received loans guaranteed thereunder, and to students who have previously received loans guaranteed thereunder except that the total of commitments so authorized may not exceed the sum of $275,000,000 plus any uncommitted balances of loan guarantee authority provided for any prior fiscal year which remain available for fiscal year 1986] *so long as the student loan insurance fund maintains a positive balance:* 10/ *Provided*[*further*], *That the provisions of section 741(i) of the Public Health Service Act shall also apply to schools participating in the Nursing Student Loan program or lenders participating in the Health Education Assistance Loan Program:* 11/ *Provided further,* That during the fiscal year, and within the resources and authority available under section 338 of the Public Health Service Act, gross obligations for the principal amount of direct loans under sections 335(c), 338(e)(1), and 338E of that Act shall not exceed $1,000,000.

(Department of Health and Human Services Appropriation Act, 1986; additional authorizing legislation to be proposed for $421,986,000; 12/ *legislative*

action required.] *Provided further,* **[That notwithstanding any other provision of this Act, amounts otherwise provided by this Act for the following accounts and activities are reduced by the following amounts:**

Health Resources and Services

"National Health Service Corps, $5,000,000.] *Public Law 99-178, (Department of Labor, Health and Human Services and Education and Related Agencies Appropriation Act, 1986; Public Law 99-190, making further continuing appropriations for fiscal year 1986.*

Explanation of Language Changes

1/ Titles IV, VII, VIII, XV, and XVI are not required because funding is not requested for the health professions (titles IV, VII and VIII) and health planning (title XV) and health resources development programs (title XVI).

2/ Provides language in the Health Resources and Services appropriation for: the monitoring of loan collections and the payment of interest subsidies of previously committed loans under titles VII, VIII, XIII, and XVI of the PHS Act.

3/ Section 427(a) of the Federal Coal Mine Health and Safety Act is no longer required because proposed legislation would include the Black Lung activity authorized by this Act in the Primary Care Block Grant.

4/ This language is no longer required. No funds are requested for assistance to two-year medical and osteopathy schools, assistance for organ procurement organizations, and construction of and equipment for outpatient medical facilities.

5/ This language is no longer required because funding is not required for these activities.

6/ Provides updated language in the Health Resources and Services appropriation to allow annual funding for maintenance and repairs at the Gillis W. Long Hansen's Disease Center.

7/ Provides language to reauthorize and expand the primary care block grant to include the migrant health, black lung clinics, and family planning program.

8/ This language authorizes funds collected from user fees, under the user fee statute (31, U.S.C. 9701), for the qualification of Health Maintenance Organizations, the eligibility determination for Comprehensive Medical Plans, and Hill-Burton loan modifications to be retained and credited to this appropriation rather than returned to Treasury as miscellaneous receipts.

9/ This language is not required. This language provides a limitation on the amount of available reimbursements from the FEOH program. This language also prohibits any new contracts or cooperative agreements to States for monitoring of operations of Community Health Health and Migrant Health Centers.

10/ Provides language in the Health Resources and Services appropriation to have lenders share in 20 percent of the loan liability, to limit the amount of new loans guaranteed under the Health Professions Graduate Student Loan Program (HEAL) in 1987 and to terminate that authority if, at any time, the Student Loan Insurance Fund goes into a negative balance.

11/ Provides language to allow lenders to charge borrowers life insurance fees on unpaid balances of guaranteed loans in both the Nursing Student Loan and HEAL programs.

12/ Cites proposed authorizing legislation for the National Health Service Corps ($46,996,000) and Primary Care Block Grant program ($375,000,000)

HEALTH RESOURCES AND SERVICES
Language Analysis

Language Provision	Explanation
Provided further, That not to exceed $10,000,000, derived in accordance with 31 U.S.C. 9701, is to be credited to this appropriation.	HRSA proposes to credit to the appropriation user fees collected from the qualification of Health Maintenance Organizations, the eligibility determination for Comprehensive Medical Plans and Hill-Burton loan modifications.
Provided, That this appropriation shall be available for payment of the costs of medical care, related expenses, and burial expenses hereafter incurred by or on behalf of any person who has participated in the study of untreated syphilis initiated in Tuskegee, Alabama, in 1932, in such amounts and subject to such terms and conditions as prescribed by the Secretary of Health and Human Services and for payment, in such amounts and subject to such terms and conditions, of such costs and expenses hereafter incurred by or on behalf of such person's wife or offspring determined by the Secretary to have suffered injury or disease from syphilis contracted from such person.	There is no authorizing legislation for this provision. This language provides the authority to pay medical and burial expenses for individuals who participated in the untreated syphilis study in Tuskegee, Alabama, in 1932, and their wife or offspring.
Provided further, That when the Department of Health and Human Services administers or operates an employee health program for any Federal department or agency, payment for the full estimated cost shall be made by way of reimbursement or in advances to this appropriation.	The Economy Act of 1932 authorized the crediting of reimbursements to regular appropriation accounts and the crediting of advances to special funds; however, this provision authorizes the crediting of both reimbursements and advances to a regular appropriation account.

Provided further, That one of the funds made available by this Act shall be used to provide special retention pay (bonuses) under paragraph (4) of 37 U.S.C. 302(a) to any regular or reserve officer of the Public Health Service for any period during which the officer is providing obligated service under section 338B (or under former sections 225(e) or 752) of the Public Health Service Act except that this proviso shall not apply to any period of service covered by an agreement entered into by an officer under 37 U.S.C. 302(c)(1) before the date of enactment of Public Law 97-377.	This language repeals the payment of special retention pay to NHSC Commissioned medical officers for any period during which the officers are providing obligated scholarship service, excluding those covered by an agreement entered into prior to the enactment of Public Law 97-377, December 18, 1982 (the first Act to include this repeal provision).
Provided further, That during fiscal 1987, the Secretary of Health and Human Services shall enter into commitments totalling $100,000,000 to guarantee up to 80 per centum of the value of Health Education Assistance Loans under subpart 1 of part C of title VII of the Public Health Service Act, so long as the Student Loan Insurance Fund maintains a positive balance.	Provides a limit in the appropriations language on the level of new loans which may be guaranteed for up to 80 percent under the Health Professions Graduate Student Loan (HEAL) program.
Provided further, That the provisions of section 741(i) of the Public Health Service Act shall also apply to schools participating in the Nursing Student Loan program or lenders participating in the Health Education Assistance Loan program.	This provision allows lenders to charge borrowers life insurance fees on unpaid balances of guaranteed loans.
Provided further, That during the fiscal year, and within the resources and authority available under section 338 of the Public Health Services Act, gross obligations for the principal amount of direct loans under sections 335(c), 338(e)(1), and 338E of that Act shall not exceed $1,000,000.	This provision limits, for fiscal year 1987, the gross obligations for the principal amount of direct loans made by the National Health Service Corps loan programs as authorized by sections 335(c) (community site loans), 338C(e)(1) and 338E (private practice loans) of the PHS Act.

HEALTH RESOURCES AND SERVICES ADMINISTRATION
Health Resources and Services
Amounts Available for Obligation

	1985	1986	1987
Appropriation:			
Annual	$1,500,222,000	$1,497,934,000	$1,162,670,000
Reappropriation (P.L. 99-88)	5,000,000	---	---
Enacted supplemental	4,500,000	—	—
Sequester order	—	-49,713,000	---
Proposed rescission	—	-206,455,000	---
Subtotal, adjusted appropriation	1,509,722,000	1,241,766,000	1,162,670,000
Comparative transfers to:			
Office of the Assistant Secretary for Health for SLUC	-52,000	—	---
Office of the Assistant Secretary for Health for AIDS	-5,000,000	—	---
Subtotal, adjusted budget authority	1,504,670,000	1,241,766,000	1,162,670,000
Receipts and reimbursements from:			
Federal sources:			
Federal employee health program	15,478,000	17,200,000	18,263,000
Non-Federal sources:			
User fees			10,000,000
Unobligated balance, start of year	28,952,000	42,439,000	14,929,000
Proposed rescission of unobligated balance	—	-5,000,000	---
Unobligated balance, end of year	-42,439,000	-14,929,000	-14,929,000
Unobligated balance, lapsing	-12,054,000	-285,000 1/	---
Total, obligations	1,494,607,000 2/	1,281,191,000 2/	1,190,933,000 2/

1/ Includes $285,000 required by Section 515 of the Treasury-Postal Services Appropriation Act of 1986.

2/ Excludes the following amounts for reimbursable activities carried out by this account: 1985 — $14,103,000 and 71 FTEs; 1986 -- $4,736,000 and 74 FTEs; 1987 -- $3,917,000 and 74 FTEs.

HEALTH RESOURCES AND SERVICES

Summary of Changes

1986 Estimate	$1,497,934,000
1986 Sequester order	-49,713,000
1986 Proposed Rescission	-206,455,000
1986 Proposed Rescission of 1985 unobligated balances	(-5,000,000)
Total estimated budget authority	1,241,766,000
(Obligations)	(1,281,191,000)
1987 Request	1,162,670,000
(Obligations)	(1,190,933,000)
Net Change	-79,096,000
(Obligations)	(-90,258,000)

	1986 Base		Change from Base	
	FTE.	Amount	FTE.	Amount
Increases:				
A. **Built-in:**				
1. Within grade increases	---	$114,792,000	---	+$1,561,000
2. Increases for Federal Employee Compensation Fund, FTS, SLUC and Service and Supply Fund.	---	64,170,732	---	+2,677,000
Subtotal			---	+4,238,000
B. **Program:**				
1. Health Care Delivery and Assistance				
(a) Maternal and Child Health Block Grant	5	457,446,000	---	+20,554,000
(b) Primary Care Block Grant	---	558,926,000 1/	---	+6,174,000
(c) Hansen's Disease Ctr.	384	18,282,000	---	+289,000
(d) Buildings & Facilities	---	718,000	---	+32,000
Subtotal			---	+27,049,000
Total Increases			---	+31,287,000

	1986 Base		Change from Base	
	FTE.	Amount	FTE.	Amount
Decreases:				
A. Built-in:				
1. National Health Service Corps - Non-recurring costs associated with the continued implementation of PPO and PPA placements.	600	53,539,000 2/	---	- 7,603,000
2. Federal Emp. Occup. Health Continued phase out of direct health unit operation	225	---	-78	---
3. Direct Operations, BHCDA Non-recurring costs....	812	42,385,000	-269	-14,941,000
4. Program Management - Improved Management of Space	---	---	---	-178,000
Subtotal....................			-347	-22,722,000
B. Program:				
1. Health Professions				
(a) Financial Distress.	---	3,924,000	---	-3,924,000
(b) Family Medicine/General Dentistry Residency and Training...........	---	13,000,000 3/	---	-13,000,000
(c) General Internal Medicine and Pediatrics	---	5,842,000 4/	---	-5,842,000
(d) Area Health Education Centers............	---	4,743,000 5/	---	-4,743,000
(e) Disadvantaged Assistance.........	---	13,000,000 6/	---	-13,000,000
(f) Health Professions Analytical Studies and Reports............	---	1,500,000 7/	---	-1,500,000

	1986 Base		Change from Base	
	FTE.	Amount	FTE.	Amount
(g) Advanced Nurse Education..........	—	3,719,000 8/	—	-3,719,000
(h) Nurse Pract./Midwife	—	378,000 9/	—	-378,000
(i) Nursing Special Projects...........	—	2,345,000 10/	—	-2,345,000
(j) Nursing Fellowships	—	733,000 11/	—	-733,000
(k) Nursing Research Grants.............	—	1,493,000 12/	—	-1,493,000
(l) Direct Operations..	330	15,040,000 13/	-258	-11,739,000
2. Health Maintenance Organizations and Resources Development				
(a) Local Planning......	—	3,440,000 14/	—	-3,440,000
(b) Outpatient Facilities Construction........	—	750,000 15/	—	-750,000
(c) Health Teaching Facilities..........	—	1,148,000	—	-1,148,000
(d) Direct Operations...	364	18,764,000 16/	-121	-13,565,000
3. Program Management......	324	18,151,000 17/	-79	-6,322,000
Subtotal, Program Decreases			-458	-87,661,000
Total Decreases............			-805	-110,383,000
Net change................	—	—	-805	-79,096,000

1/ Reflects a proposed rescission of $21,646,000.

2/ Reflects a proposed rescission of $2,445,000.

3/ Reflects a proposed rescission of $21,452,000.

4/ Reflects a proposed rescission of $11,862,000.

5/ Reflects a proposed rescission of $12,483,000.

6/ Reflects a proposed rescission of $11,403,000.

7/ Reflects a proposed rescission of $414,000.

8/ Reflects a proposed rescission of $12,071,000.

9/ Reflects a proposed rescission of $11,106,000.

10/ Reflects a proposed rescission of $6,747,000.

11/ Reflects a proposed rescission of $1,181,000.

12/ Reflects a proposed rescission of $7,790,000.

13/ Reflects a proposed rescission of $4,291,000.

14/ Reflects a proposed rescission of $11,566,000.

15/ Reflects a proposed rescission of $4,035,000.

16/ Reflects a proposed rescission of $1,046,000.

17/ Reflects a proposed rescission of $4,811,000.

Health Resources and Services Administration

Budget Authority by Activity
(in thousands)

	1986 Appropriation Amount	1986 Available after Sequestering Amount	1986 Revised		1987	
			FTE	Amount	FTE	Amount
1. HEALTH CARE DELIVERY AND ASSISTANCE						
A. Maternal and Child Health block grant	$478,000	$457,446	5	$457,446	5	$478,000
B. Primary Care:						
(1) Primary Care block grant........	---	---	---	---	---	565,100
(2) Community Health Centers........	400,000	396,000	---	375,000	---	---
(3) Black Lung Clinics..............	3,400	3,254	---	3,254	---	---
(4) Migrant Health..................	45,400	44,946	---	44,300	---	---
(5) Family Planning.................	142,500	136,372	---	136,372	---	---
Subtotal, Primary Care........	591,300	580,572	---	558,926	---	565,100
C. Home Health Services.................	1,500	1,435	---	---	---	---
D. National Health Service Corps.......	58,500	55,984	600	53,539	600	46,996
E. National Health Service Corps Schol.	2,300	2,201	---	---	---	---
F. Hansen's Disease Center.............	19,103	18,282	384	18,282	384	19,103
G. Payment to Hawaii...................	3,300	3,158	---	2,500	---	2,500
H. Direct Operations, BHCDA............	44,289	42,385	812	42,385	543	29,132
TOTAL BHCDA.........................	1,198,292	1,161,463	1,801	1,133,078	1,532	1,140,831

Budget Authority by Activity
(in thousands)

	1986 Appropriation	1986 Available after Sequestering	1986 Revised		1987	
	Amount	Amount	FTE	Amount	FTE	Amount
2. HEALTH PROFESSIONS						
A. Health Prof.Student Assistance...						
(1) Exceptional Need School......	7,000	6,699	---	---	---	---
Subtotal Student Assistance......	7,000	6,699	---	---	---	---
B. Health Professions Institutional Assistance						
(1) Financial Distress..........	4,100	3,924	---	3,924	---	---
(2) Two-year Med/Osteo Schools..	500	479	---	---	---	---
Subtotal Institutional Assist...	4,600	4,403	---	3,924	---	---
C. Public Health/Health Administration						
(1) Public Health Capitation....	5,000	4,785	---	---	---	---
(2) Hlth Administration Grants..	1,500	1,436	---	---	---	---
(3) Public Health Traineeships..	3,000	2,871	---	---	---	---
(4) Hlth Adm. Traineeships......	500	479	---	---	---	---
(5) Preventive Med Residencies..	1,600	1,531	---	---	---	---
Subtotal Public Hlth/Health Admin	11,600	11,102	---	---	---	---

Budget Authority by Activity
(in thousands)

	1986 Appropriation Amount	1986 Available after Sequestering Amount	1986 Revised FTE	1986 Revised Amount	1987 FTE	1987 Amount
D. Primary Care						
(1) Fam Med/Gen Dent Res & Trng.	36,000	34,452	---	13,000	---	---
(2) General Internal. Med & Ped.	18,500	17,704	---	5,842	---	---
(3) Family Medicine Departments.	7,000	6,699	---	---	---	---
(4) Physician Assistants........	4,800	4,594	---	---	---	---
Subtotal Primary Care...........	66,300	63,449	---	18,842	---	---
E. Health Prof. Special Educ.Init..	8,000	7,656	---	---	---	---
F. Area Health Education Centers...	18,000	17,226	---	4,743	---	---
G. Disadvantaged Assistance........	25,500	24,403	---	13,000	---	---
H. Hlth. Prof. Analy.Studies & Rpts	2,000	1,914	---	1,500	---	---
I. Nurse Education						
(1) Advanced Nurse Education.....	16,500	15,790	---	3,719	---	---
(2) Nurse Practitioner/Midwife...	12,000	11,484	---	378	---	---
(3) Nurse Special Projects.......	9,500	9,092	---	2,345	---	---
(4) Prof Nurse Traineeships......	11,500	11,005	---	---	---	---
(5) Nurse Research Fellowships...	2,000	1,914	---	733	---	---
(6) Nurse Research Grants........	9,700	9,283	---	1,493	---	---
(7) Nurse Anesthetists...........	800	766	---	---	---	---
(8) Nurse Demonstration Projects.	1,350	1,292	---	---	---	---
(9) Nurse Faculty Fellowships....	550	526	---	---	---	---
Subtotal Nurse Training..........	63,900	61,152	---	8,668	---	---
J. Direct Operations, BHPr...........	20,200	19,331	330	15,040	72	3,401
TOTAL HEALTH PROFESSIONS..........	227,100	217,335	330	65,717	72	3,401

BLANK PAGE

BLANK PAGE

BLANK PAGE

Budget Authority by Activity
(in thousands)

	1986 Appropriation	1986 Available after Sequestering	1986 Revised		1987	
	Amount	Amount	FTE	Amount	FTE	Amount
3. HEALTH MAINTENANCE ORGANIZATION AND RESOURCE DEVELOPMENT						
A. Local Planning....................	15,680	15,006	---	3,440	---	---
B. State Planning....................	4,800	4,594	---	---	---	---
C. Planning Methods Development......	418	400	---	---	---	---
D. Outpatient Facilities Construction	5,000	4,785	---	750	---	---
E. Health Teaching Facilities........	1,200	1,148	---	1,148	---	---
F. Direct Operations, BHMORD.........	20,700	19,810	364	18,764	243	15,628
G. User Fees.........................	---	---	---	---	---	-10,000
TOTAL BHMORD.........................	47,798	45,743	364	24,102	243	5,628
4. Building & Facilities................	750	718	---	718	---	750
5. Program Management..................	23,994	22,962	324	18,151	265	12,060
Total Budget Authority...............	1,497,934	1,448,221	2,819	1,241,766	2,092	1,162,670
Receipts and reimbursements from:						
Federal sources:						
Federal employee health program....	17,200	17,200	225	17,200	147	18,263
Non-Federal sources:						
User fees..........................						10,000
Unobligated balance, start of year...	42,439	42,439		42,439		14,929
Proposed rescission of unobligated balance............................				-5,000		
Unobligated balance, end of year.....	-14,929	-14,929		-14,929		-14,929
Unobligated balance, lapsing.........	-285 1/	-285 1/		-285 1/		---
Total, obligations...................	1,542,359	1,492,646	3,044	1,281,191	2,239	1,190,933

1/ Includes $285,000 required by Section 515 of the Treasury-Postal Services Appropriation Act of 1986.

1B. Reflects a proposed rescission of $21,646,000: $21,000,000 for Community Health Centers and $646,000 for Migrant Health.

1C. Reflects a proposed rescission of $1,435,000 for Home Health.

1D. Reflects a proposed rescission of $2,445,000 for the National Health Service Corps.

1E. Reflects a proposed rescission of $2,201,000 for the National Health Service Corps scholarship program.

1G. Reflects a proposed rescission of $658,000 for Payment to Hawaii.

2A. Reflects a proposed rescission of $6,699,000 for Exceptional Financial Need Scholarships.

2B. Reflects a proposed rescission of $479,000 for Two-year Medical and Osteopathy Schools.

2C. Reflects a proposed rescission of $11,102,000 for Health Promotion/Disease Prevention: $4,785,000 for Public Health Capitation; $1,436,000 for Health Administration Grants; $2,871,000 for Public Health Traineeships; $479,000 for Health Administration Traineeships; $1,531,000 for Preventive Medicine Residencies.

2D. Reflects a proposed rescission of $44,607,000 for Primary Care; $21,452,000 for Family Medicine/General Dentistry Residency and Training; $11,862,000 for General Internal Medicine and Pediatrics; $6,699,000 for Family Medicine Departments; $4,594,000 for Physician Assistants.

2E. Reflects a proposed rescission of $7,656,000 for Health Professions Special Educational Initiatives.

2F. Reflects a proposed rescission of $12,483,000 for Area Health Education Centers.

2G. Reflects a proposed rescission of $11,403,000 for Disadvantaged Assistance.

2H. Reflects a proposed rescission of $414,000 for Health Professions Analytical Studies and Reports.

2I. Reflects a proposed rescission of $52,484,000 for Nurse Education: $12,071,000 for Advanced Nurse Education; $11,106,000 for Nurse Practitioner/Nurse Midwife; $6,747,000 for Nurse Special Projects; $1,292,000 for Nurse Demonstration Projects; $11,005,000 for Professional Nurse Traineeships; $526,000 for Faculty Fellowships; $1,181,000 for Research Fellowships; $7,790,000 for Nurse Research Grants; $766,000 for Nurse Anesthetists.

2J. Reflects a proposed rescission of $4,291,000 for Direct Operations, BHPr.

3A. Reflects a proposed rescission of $11,566,000 for Local Planning.

3B. Reflects a proposed rescission of $4,594,000 for State Planning.

3C. Reflects a proposed rescission of $400,000 for Planning Methods Development.

3D. Reflects a proposed rescission of $4,035,000 for Outpatient Facilities Construction.

3E. Reflects a proposed rescission of $1,046,000 for Direct Operations, BHMORD.

5. Reflects a proposed rescission of $4,811,000 for the Office of the Administrator: $1,195,000 for Program Management; $1,145,000 for Facilities Planning and Engineering; and $2,471,000 for Organ Transplant.

Budget Authority by Object

	1985	1986	1987
Full-time equivalent of full-time permanent positions...........	3,015	2,892	2,003
Full-time equivalent of all other positions...............	327	152	236
Total compensable workyears...	3,342	3,044	2,239
Average ES salary..............	$68,625	$67,728	$51,638
Average GS grade...............	10.5	10.2	10.2
Average GS salary..............	$34,975	$32,450	$31,406
Average grade, grades established by Act of July 1, 1944 (42 USC 207).............	4.9	4.9	3.5
Average salary, grade established by Act ot July 1 1944 (42 USC 207).............	$38,727	$38,176	$29,608
Average salary of ungraded positions......................	$18,873	$18,873	$18,873
Personnel compensation:			
Permanent positions..........	$83,835,000	$78,167,000	$49,438,000
Positions other than permanent..................	12,839,000	11,106,000	9,502,000
Other personnel compensation...............	4,609,000	9,696,000	9,046,000
Special personal services payments....................	93,000	27,000	---
Subtotal, personnel compensation..............	101,376,000	98,996,000	67,986,000

Personnel benefits.............	17,451,000	15,796,000	12,526,000
Benefits for former personnel..	137,000	111,000	---
Travel and transportation of persons......................	5,335,000	4,579,000	3,406,000
Transportation of things.......	3,010,000	3,051,000	2,731,000
Rent, communications, and utilities....................	4,004,000	4,198,000	2,899,000
Standard level user charges....	5,154,000	5,016,000	2,358,000
Printing and reproduction......	670,000	634,000	336,000
Other services.................	24,190,000	17,416,000	14,013,000
Project contracts..............	22,247,000	9,234,000	6,644,000
Supplies and materials.........	2,195,000	1,370,000	1,676,000
Equipment......................	2,082,000	1,591,000	1,034,000
Investments and loans..........	507,000	957,000	1,000,000
Grants, subsidies and contributions................	1,316,235,000	1,078,817,000	1,046,061,000
Insurance claims and indemnities.................	77,000	---	---
Total budget authority by object......................	$1,504,670,000 2/	$1,241,766,000 3/	$1,162,670,000
(Total obligations)..........	($1,494,607,000)	($1,281,191,000)	($1,190,933,000)

1/ Includes the following reimbursable FTEs: 1985 - 265 FTEs; 1986 - 225 FTEs; and 1957 - 147 FTES.

2/ Includes lapsed amount of $5,011,000.

3/ Includes $285,000 which would lapse based on Section 515 of the Treasury-Postal Services Appropriation Act of 1985, a reduction of $49,713,000 pursuant to the Balanced Budget and Emergency Deficit Control Act of 1985, P.L. 99-177, and a proposed rescission of $206,455,000 from the 1985 Appropriation Act and $5,000,000 from the unobligated balance.

Significant Items in House and Senate Appropriation Committees Reports

Item	Action Taken or To Be Taken
1986 Senate Report (No. 99-151)	
Maternal and Child Health Block Grant	
Needs of Hispanic Women	
"Hispanic women have the highest fertility rates of any sub-population in the United States. This data, in combination with the youthfulness of the population and the prevalence of risk factors such as poverty, low levels of education, teen pregnancy, and others, suggest the possibility of extensive health problems for Hispanic women in the childbearing years. Other data have shown that some segments of the Hispanic population have high proportions of low birth weight babies, yet another indication of potential problems affecting the survival and quality of life for Hispanic infants. The Committee directs the Public Health Service to address this problem through expanded programs targeting high-risk Hispanic populations, focusing on educational efforts aimed at increasing knowledge of preventive measures and increase of preventive services, particularly in the prenatal period." (p. 29)	The Division of Maternal and Child Health has several major activities planned for FY 1986 which impact directly on high risk Hispanic populations. Foremost are the Maternal and Child Health Improvement Projects which include the development of systems of risk-appropriate maternal/perinatal health care; programs to prevent postneonatal mortality; and projects to achieve early continuous prenatal care among women likely to register late or receive no care. Hispanics are prominent among the target populations. Additional activities include expansion of education through the Healthy Mothers/Healthy Babies Coalition, media campaigns in Spanish, publications in Spanish, and assessment of needs of Hispanic (and other minority) populations.
Community Health Centers	
Fund Allocation	
"The Committee is once again deeply concerned that virtually all of the additional funds provided in recent years have gone for new or special activities, while relatively little is being used to offset increased costs at existing centers - contrary	The Bureau of Health Care Delivery and Assistance will allocate funds for grants to Community Health Centers based on requirements to cover increased operating costs balanced by the need for new services in high priority underserved areas. Emphasis

to the explicit directives of this Committee. Our concern continues to be that this policy may adversely affect the quality of patient care. Moreover, a new highly questionable policy (zero-based assessments) was implemented this year, and the Committee is concerned with its impact.	will continue to be placed upon improving operating efficiency, including collecting third-party payments and controlling overhead costs.
Accordingly, the Committee directs the following:	
One, that the Secretary maintain current services levels at existing centers before any amounts may be spent for new activities including NHSC conversions.	
Two, that by no later than December 31, 1985, the Department shall submit to the Committee a report listing each center by State, detailing the level of operational grant support for each of the last 3 fiscal years (fiscal years 1983-85), showing the number of registered patients and patient encounters for each year, and listing the physicians by specialty for each center.	Due to the fact that data on fiscal year 1985 will not be available until March 15, 1986, the Bureau of Health Care Delivery and Assistance proposes to submit the requested report by April 1, 1986. An interim report with data on fiscal years 1983 and 1984 will be submitted prior to the FY 1987, Appropriation hearings.
Three, that by February 15, 1986, the Department project the amounts required to implement the true costs of its remaining NHSC conversion policy to include salary, fringe and malpractice costs for each obligee not converted under this appropriation for either community or migrant health centers. This report should include an estimate of conversion cost per person and a projection of the number to be converted." (p. 30)	The report will be submitted.
Cooperative Agreements	
"The Committee is deeply concerned with recent efforts by the Department to circumvent clear direction set by this and the authorizing committees with respect to the administration of community and migrant health centers. Again this year, the Senate has	The Bureau of Health Care Delivery and Assistance will adhere to the prohibition contained in the final bill language regarding funding new cooperative agreements which include administrative or monitoring activities.

passed legislation (S. 1282) which retains Federal management and specifically repeals a State-administered block grant approach for these programs. Despite this clear direction, the Department has proposed to fund States not only for planning, but also for administrative activities under cooperative agreements. The Committee is pleased with the record of efficiency and effectiveness compiled by the health centers under Federal management. Therefore, in light of scarce resources, the Committee does not approve of this costly new activity and has included bill language prohibiting the use of funds for administrative and monitoring activities, which duplicate current Federal management responsibilities. This prohibition would not apply to contracts with States for National Health Service Corps activities or to cooperative efforts involving planning for primary care services." (p. 30)

National Health Service Corps

"The Department is directed to maintain its efforts with the University of Hawaii School of Medicine under the National Health Service Corps program until a comprehensive strategy is developed for the Pacific basin region which takes into account the recommendations of the HHS Pacific Basin Task Force." (p. 32-33)

A contract with the University of Hawaii is being continued through FY 1986.

Federal Employee Occupational Health

"The Committee directs the Department to provide, by March 1986, a detailed study of Federal Employee Occupational Health operations and alternative for carrying out and financing these functions in the most efficient and effective manner to provide state-of-the-art comprehensive occupational health care. Until this is submitted, the Committee directs that there be no reduction in staff or services." (p. 33)

The Bureau of Health Care Delivery and Assistance will submit the report as requested.

Organ Procurement and Transplantation Network

"The Committee expects the Secretary to award a contract for the Organ Procurement and Transplantation Network required by section 372 of the Public Health Service Act not later than December 15, 1985." (p. 34)	Funds for the network were released January 9, 1986. Contract award is now planned for early June 1986.

Family Medicine/General Dentistry Residencies and Training

"The Committee directs that at least $2,000,000 of the total amount recommended be allocated to support advanced education in general dentistry." (p.37)	The FY 1986 rescission budget proposes a reduction in this program. The Department has allotted $1,000,000 for the general dentistry residencies and training program in accordance with the 7-1/2% authorization provision for the Family Medicine/General Dentistry Residencies and Training program.

Health Professions Data Analysis

"For the past 5 years the Committee has urged HRSA to develop comprehensive generic-oriented mental health shortage designations in order to ensure that the Committee has the most up-to-date information available. The Committee has been assured that the Department is proceeding in this direction. The Committee urges HRSA to complete this task in a timely fashion." (p. 38)	The Department is currently engaged in the second phase of a multi-phase project to develop mental health manpower shortage criteria. Phase I has been completed and Phase II will be completed in March, 1986. Funds are not included under the Health Professions Analytical Data Analysis program in the FY 1986 Rescission Budget or the FY 1987 President's Budget to fund any future phases of the multi-phase project on mental health manpower shortage criteria.

Health Professions Special Education Initiatives

"The country is currently experiencing a critical shortage of practicing podiatrists. Apart from its effect on the general population, the shortage is having a particularly severe impact on poor and elderly persons living in medically underserved areas. The Committee, therefore, expects that a portion of the funds provided for this activity be used to continue the podiatric medicine training grant program at the fiscal year 1985 funding level." (p. 39)	The FY 1986 Rescission Budget proposes to eliminate the Health Professions Special Educational Initiative program. The podiatric specialty training program will not be funded.

Special Pacific Basin Initiatives

"The Committee was distressed that it took HRSA nearly a full year to even begin negotiations with the John A. Burns School of Medicine to initiate the Pacific basin medical officers training project on Ponape. Funds were made available for this project during the regular fiscal year 1985 appropriations process, and the program is urgently needed to address the pressing health delivery problems of the region. The Committee expects HRSA to be more responsive to this program in the future." (p. 39)	The Department awarded a grant to the John A. Burns School of Medicine on January 7, 1986, for $2,500,000.

Advanced Nurse Education

"The Committee has learned that the Division of Nursing presently does not accept applications submitted by Schools of Nursing which address the area of mental health care." (p. 40)	Prior to FY 1986, the Department designated six clinical specialties (with preferential funding given to 3 specific areas) eligible for Advanced Nurse Education support. Any applications received in the area of psychiatric mental health nursing were referred to other parts of the Department, specifically the National Institute of Mental Health which has a program for Psychiatric Mental Health Nursing. In view of the FY 1986 Rescission Budget request and the Department's policy of awarding continuations prior to any new awards, any psychiatric mental health nurse applications received by the Division of Nursing will continue to be referred to the National Institute of Mental Health.

Nursing Mental Health Grants

"The Committee believes that the systematic exclusion of applications addressing this subject matter is highly inappropriate and, accordingly, directs the Division of Nursing to begin funding appropriate applications in the mental health area. The Committee further directs the Department to provide the Committee by March 1, 1986, with a report on those mental health grants which have been referred to another part of the Department." (p. 40)	A report is being prepared on Nursing mental health grants. The report will be submitted to the Committee by March 1, 1986.

Nursing Education Activities

"With increasing Congressional consideration being given to significantly modifying the present medicare nursing education provisions, the Committee believes that it is important that HRSA develop a comprehensive report on nursing education activities reimbursable under Medicare and the extent to which these may have to be taken up by HRSA. The Committee is especially interested in that aspect of nurse training which involves the provision of clinical services by nursing students." (p.40)	A report is being prepared on nursing education activities reimbursable under Medicare. The report will be submitted prior to the FY 1987 Appropriation hearings.

Nurse Demonstration Projects

"The Committee is also aware that over the last several years there have been numerous legislative proposals to provide direct reimbursement for nursing services under Federal health programs. While conceptually supportive of direct reimbursement for nurses; many Federal policymakers have expressed a desire for more data about the cost-effectiveness of nursing care. The Committee directs the Secretary to fund projects to demonstrate improved methods of expanding access to nursing practice arrangements in the community. Such demonstrations should provide information on the costs, effectiveness, and accessibility of such projects and on payment policy and problems. The Committee expects that the knowledge gained from this authority will provide the Federal Government and private payers with valuable experience to study proposals for changes in reimbursement policy." (p. 42)	The FY 1986 Rescission Budget proposes to eliminate the Nurse Demonstration program. Projects to demonstrate improved methods of expanding access to nursing practice arrangements in the community will not be funded.

1986 House Report (No. 99-289)

Federal Employee Occupational Health

"The bill specifies that the level of operations for this program be maintained at the FY 1985 level of $15,750,000. This action is being taken as an interim measure in FY 1986 pending submission to the Committee of a more workable plan which both maintains services and protects the rights of the career employees who staff these units." (p. 26)	A report will be submitted to the Committee by the end of March 1986.

Organ Transplant Grants

"The Committee has deferred consideration of funding for this activity pending the report of the Task Force which, among other things, is reviewing the nature and extent of the Federal role in this area." (p. 26)	The final report is expected to be completed in March, 1986. It will be submitted directly to the Secretary and Congressional Committees by the Task Force.

1986 House Conference Report (No. 99-402)

Community Health Centers

"The conferees are agreed that the amount provided includes funding for selective increases to offset the cost of inflation for grantees who need such assistance. The conferees are agreed, however, that the need for such assistance must be balanced with the need for new services and the need to manage programs as efficiently as possible. This includes continued emphasis to maximize third party reimbursements and to control expenses, especially overhead costs." (p. 13)

The Bureau of Health Care Delivery and Assistance will allocate funds for grants to Community Health Centers based on requirements to cover increased operating costs balanced by the need for new services in high priority underserved areas. Emphasis will continue to be placed upon improving operating efficiency, including collecting third-party payments and controlling overhead costs.

Two-Year Medical and Osteopathy Schools

"The conference agreement also earmarks $500,000 for grants to 2 year schools of medicine or osteopathy under section 788(a) of the Public Health Service Act as proposed by the Senate. The House bill included no similar provision." (p. 14)

The FY 1986 Rescission Budget request proposes to eliminate funds for this program.

Health Professions Special Educational Initiatives

"The conference agreement includes $3 million for Health Professions Special Educational Initiatives. The conferees recommend that up to $500,000 of these funds be made available for the planning and development of a program of computer-based simulations for medical training, in such fields as arthroscopy, on the basis of their understanding that the use of this new technology could lead to major improvements in the training of health professionals, especially surgeons, by allowing them to learn and practice their skills, not on live patients, but on computer simulations, and by permitting new methods of testing and accrediting their knowledge and competence." (p. 14)

The FY 1986 Rescission Budget proposes to eliminate the Health Professions Special Educational Initiative program. A program on computer-based simulations for medical training will not be funded.

Geriatric Training Initiatives

"Earmarks $5,000,000 for geriatric educational units as proposed by the Senate. The House bill contained no similar provision." (p. 15)	The FY 1986 Rescission Budget proposes to eliminate the Geriatric Training Initiatives, therefore, the geriatric educational units will not be funded.

Cooperative Agreements

"The conferees are concerned with the recent practice of the Bureau of Health Care Delivery and Assistance allowing States to administer portions of the Community and Migrant Health Centers programs through "Cooperative Agreements." It is requested that the Bureau prepare a detailed report on the status of the existing agreements in preparation for appropriation committee hearing on the matter by March 1, 1986." (p. 15)	The requested report will be submitted.

Authorizing Legislation

	1986 Amount Authorized	1986 Current Estimate	1987 Amount Authorized	1987 Budget Request
1. Health Care Delivery And Assistance				
A. Maternal and Child Health Block Grant (Title V of the Social Security Act)	$478,000,000	$457,446,000	$478,000,000	$478,000,000
B. Primary Care:				
(1) Primary Care block grant	---	---	1/	565,100,000
(2) Community Health Centers (PHS Act, Sec 1922)	2/	375,000,000	---	---
(3) Black Lung Clinics (Federal Mine & Safety Act of 1977 (Sec 427(a)))	10,000,000	3,254,000	10,000,000	---
(4) Migrant Health (PHS Act Sec 329)	2/	44,300,000	---	---
(5) Family Planning (PHS Act, Title X)	2/	136,372,000	---	---
C. Home Health Services (PHS Act, Sec 339)(a)(b)	7,000,000	---	7,000,000	---
D. National Health Service Corps (PHS Act, (Sec 331-338)	2/	53,539,000	3/	46,996,000
E. National Health Service Corps Schol. (PHS ACT (Sec 338A,B,D,F)	2/	---	4/	---
F. Hansen's Dis.Center (PHS Act, Sec 320,Title V)	Indefinite	18,282,000	Indefinite	19,103,000
G. Federal Employee Occup. Health (5 USC 7901)	Indefinite	---	Indefinite	---
H. Payment to Hawaii (PHS Act, Sec. 320)	Indefinite	2,500,000	Indefinite	2,500,000
I. Direct Operations, BHCDA (see above citations)	Indefinite	42,385,000	Indefinite	29,132,000
2. Health Professions				
A. Health Professions				
(1) Health Professions Student Assistance Exceptional Financial Need Scholarships (PHS Act, Sec. 758 (d))	7,000,000	---	7,000,000	---
(2) Health Professions Institutional Assistance Advanced Financial Distress (PHS Act, Sec 788B)	4,200,000	3,924,000	3,800,000	---

Authorizing Legislation

	1986 Amount Authorized	1986 Current Estimate	1987 Amount Authorized	1987 Budget Request
(3) Health Promotioin/Disease Prevention				
Public Health Cap. (PHS Act, Sec 770(e))	5,000,000	---	5,125,000	---
Health Admin. Grants (PHS Act, Sec 791)	1,500,000	---	1,500,000	---
Public Health Traineeships (PHS Act, Sec 792)	3,000,000	---	3,075,000	---
Health Admin.Traineeships (PHS Act, Sec 791A)	500,000	---	500,000	---
Preventive Med. Resid. (PHS Act, Sec 793)	1,600,000	---	1,600,000	---
(4) Primary Care:				
Family Med/General Dent Resid & Training (PHS Act, Sec 786)	36,000,000	13,000,000	37,000,000	---
General Medicine & Ped. (PHS Act, Sec 784)	18,500,000	5,842,000	19,500,000	---
Family Medicine Dpts (PHS Act, Sec 780)	7,000,000	---	7,000,000	---
Physician Assistants (PHS Act, Sec 783)	4,800,000	---	4,800,000	---
(5) Health Prof. Special Educ Initiatives PHS Act, Sec 788 (b-f)	8,000,000	---	8,000,000	---
(6) Area Health Education Centers (PHS Act, Sec 781)	18,000,000	4,743,000	18,000,000	---
(7) Disadvantaged Assistance (PHS Act, Sec 787)	26,000,000	13,000,000	28,000,000	---
(8) Health Prof. Analytical Studies & Reports (PHS Act, Sec 301, 332, 708)	Indefinite	1,500,000	Indefinite	---
8. Nurse Education:				
(1) Advanced Nurse Education(PHS Act, Sec 821)	16,500,000	3,719,000	17,000,000	---
(2) Nurse Pract./Midwife(PHS Act, Sec 822)	12,000,000	378,000	12,000,000	---
(3) Nurse Special Projects (PHS Act, Sec 820)	9,500,000	2,345,000	9,500,000	---
(4) Profess. Nurse Trainee. (PHS Act, Sec 830)	11,500,000	---	12,250,000	---
(5) Nurse Research Fellowships (PHS Act, Sec 487)	5/	733,000	5/	---
(6) Nurse Research Grants (PHS Act, Sec 301)	Indefinite	1,493,000	Indefinite	---
(7) Nurse Anesthetists (PHS Act, Sec 831 (b))	800,000	---	800,000	---
(8) Nurse Demon. Grants (PHS Act, Sec 820(d)(2))	2,700,000	---	2,700,000	---
(9) Nursing Faculty Fellow. (PHS Act, Sec 830(c)(2))	1,100,000	---	1,100,000	---

Authorizing Legislation

	1986 Amount Authorized	1986 Current Estimate	1987 Amount Authorized	1987 Budget Request
C. Direct Operations, BHPr (see above citations)	Indefinite	15,040,000	Indefinite	3,401,000
3. Health Maintenance Organization and Resource Development				
A. Local Planning (Title XV of the PHS Act)	6/	3,440,000	7/	---
B. State Planning (Title XV of the PHS Act)	6/	---	7/	---
C. Planning Methods Development (Title XV of the PHS Act)	6/	---	7/	---
D. Outpatient Facilities Construction (Title XVI of the PHS Act)	---	750,000	---	---
E. Hlth Teaching Facil (PHS Act, Sec 726 & 805)	Indefinite	1,148,000	Indefinite	---
F. HMO Management Training & Technical Ass't (PHS Act, Sec 1317)	Indefinite	---	Indefinite	---
G. Direct Operations, BHMORD (see above citations and parts A & C of Title XVI)	Indefinite	18,764,000	Indefinite	15,628,000
H. User Fees (31 U.S.C. 9701)		---		-10,000,000
4. **Building & Facilities** (PHS Act, Sec 321(a))	Indefinite	718,000	Indefinite	750,000
5. **Office of the Administrator** (see above citation)	Indefinite	17,751,000	Indefinite	12,060,000
6. **Organ Procurement and Transplantation** (PHS Act, Title III, Section 371 & 372)	10,000,000	400,000	14,000,000	---
Unfunded Authorizations				
(1) Emergency Medical Services for Children (PHS Act, Section 1910)	2,000,000	---	2,000,000	---
Total Appropriation		1,241,766,000		1,162,670,000
Total Appropriation against definite authorization	702,200,000	508,051,000	711,250,000	478,000,000

122

Authorizing Legislation (Continued)

1/ New legislation to be proposed.

2/ No specific authorization, these programs were first authorized by the Continuing Resolution, then P.L. 99-178 appropriated amounts for the remainder of the year.

3/ Authorization expired September 30, 1984. New legislation to be proposed.

4/ Authorization expired September 30, 1984.

5/ Authorized under the Health Research Extension Act, P.L. 99-158, which includes the National Institutes of Health and others. Total funds authorized, FY 1986: $244,000,000; FY 1987: $260,000,000.

6/ No specific authorization, P.L. 99-178 extends authorization and provides funding for the Health Planning program through September 30, 1986.

7/ Authorization expired September 30, 1982.

Health Resources and Services

Table of Estimates and Appropriations

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriations 1/
1978	1,681,645,500	1,976,856,000	2,241,561,500	2,109,367,500
1979	2,229,608,500	1,844,471,500	1,818,694,500	2,156,518,084
1980	1,935,661,500	1,818,253,000	2,042,676,500	2,209,874,000
1981	1,728,637,000	1,593,350,000	—	1,682,272,000
1982	456,272,000 2/	1,329,373,000	1,342,017,000	1,474,651,000
1983	1,083,313,000	1,414,159,000	1,460,442,000	1,509,615,000
1984	279,944,000 2/	1,252,783,000	1,363,399,000	1,380,151,000
1985	245,419,000 2/	3/	1,455,289,000	1,505,222,000
1985 Supplemental				4,500,000
1986	1,157,393,000	564,853,000 4/	1,408,979,000 4/	1,497,934,000
1986 Sequester	-49,713,000			
1986 Proposed Rescission	-206,455,000			
1987	1,162,670,000			

1/ Reflects enacted supplementals, rescissions and reappropriations.

2/ Excludes funds for those block grants which were proposed for transfer to OASH.

3/ The House did not consider funding for Health Resources and Services because a large portion of funds requested were not authorized.

4/ The House and Senate deferred action on funding consideration for some programs within the Health Resources and Services account because of lack of authorization.

JUSTIFICATION

HEALTH RESOURCES AND SERVICES ADMINISTRATION

Health Resources and Services

	FY 1986 Revised Estimate		FY 1987		Increase or Decrease	
	FTE	Amount	FTE	Amount	FTE	Amount
Health Resources and Services:						
1. Health Care Delivery and Assistance	2,026	$1,133,078,000	1,679	$1,140,831,000	-347	+$7,753,000
2. Health Professions	330	65,717,000	72	3,401,000	-258	-62,316,000
3. Health Maintenance Organizations and Resources Development	364	18,764,000	243	5,628,000	-121	-13,136,000
4. Building and Facilities	---	718,000	---	750,000	---	+32,000
5. Program Management	324	18,151,000	245	12,060,000	-79	-6,091,000
TOTAL	3,044	$1,241,766,000	2,239	$1,162,670,000	-805	-$79,096,000

GENERAL STATEMENT

The Health Resources and Services appropriation supports the program activities of the Health Resources and Services Administration which: provide or arrange for personal health services, including both hospital and outpatient care, to designated beneficiaries; improve the education, training, distribution, supply, use and quality of the Nation's health personnel, with emphasis on programs which benefit minorities and the disadvantaged; support efforts designed to integrate health services delivery programs with public and private health financing programs, including health maintenance organizations; improve the utilization of health resources; and provide technical assistance for modernizing or replacing health care facilities.

The President's appropriation request of $1,162,670,000 for this account includes current law adjusted by a net increase of $190,100,000 assuming congressional action on proposed legislation as follows:

Current law estimate	$982,570,000
Impact of legislative changes:	
— Increase for the consolidation of categorical programs (family planning, migrant health, and black lung clinics) with the primary care block grant	+$190,100,000
Subtotal, legislative changes	+$190,100,000
Total appropriation request in President's budget	$1,162,670,000

The Bureau of Health Care Delivery and Assistance will continue to assist with the delivery of primary health care services, preventive health care, health promotion activities and occupational health care. The Maternal and Child Health Service Block Grant provides funding for State-initiated programs for mothers and children, and between 10 and 15 percent of its annual appropriation is set aside for special projects of regional or national significance.

During FY 1986, the Primary Care programs will provide access to health services for approximately 9,500,000 people through 718 grantees. Along with Community Health Centers, care will be provided through the Migrant Health Program, Black Lung Clinics and the Family Planning Program. New legislation is being proposed to bring the latter three programs into the Expanded Primary Care Block Grant.

In addition, the Bureau will continue to coordinate the efforts of the National Health Service Corps to improve the accessibility of health services in underserved areas through the appropriate placement of health professionals as private practitioners or federally-employed personnel. The Bureau will also manage the Gillis P. Long Hansen's Disease Center at Carville, Louisiana, the Federal Employee Occupational Health Program, and the Federal payment to Hawaii for treatment of persons with Hansen's Disease.

Federal efforts in support of the health professions have resulted in long-term trends of steadily increasing supplies of physicians and nurses and an improvement in the distribution of health care practitioners among the medically underserved areas of the country. At the same time. cumulative Federal contributions to health professions and nursing student loan funds, combined with Health Educational Assistance Loans (HEAL) loan guarantees, have put in place a foundation of Federal health professions student aid which will amount to approximately $167 million in 1987. Because of this, programs providing general support to health education to increase the numbers of and improve the distribution of practitioners are no longer needed.

It is in recognition of these trends and in light of overall national funding constraints that the Administration proposes discontinuation of health professions education subsidies in FY 1987. Funds are requested for direct operations of the Bureau of Health Professions to administer the HEAL program, Student Loan Insurance Fund, Health Professions and Nursing Student Loan revolving funds, and for debt management and collection activities.

Activities of the Bureau of Health Maintenance Organizations and Resources Development supported by the FY 1987 request include: conducting qualification of Health Maintenance Organizations (HMOs) and determinations of eligibility to contract with HCFA to receive Medicare funds for Competitive Medical Plans (CMPs); ensuring the continued compliance of all qualified HMOs with existing statutory and regulatory requirements; assisting facilities receiving Federal funds in complying with requirements to furnish a reasonable level of uncompensated care to persons unable to pay; administering programs which monitor health facility construction grants including recovery of Federal monies where required and promotion of cost savings through energy conservation; monitoring approximately $3.0 billion in outstanding loans and loan guarantees to minimize Federal default liability; and reviewing and recommending approval of applications from health facilities seeking mortgage insurance under Section 242 of the National Housing Act and monitoring of outstanding insured loans. In 1987, the cost of providing some of these services will be offset by charging fees to users and applicants who benefit from these services. About $10 million is expected to be earned through this mechanism. Appropriation language is requested to credit the HRSA appropriation with collections from the user fee.

The health planning programs administered by this Bureau were funded only through September 30, 1986 by the current appropriation pending consideration of Congressional authorization proposals. The Administration does not propose further funding of these programs because the authorizing statute has expired, and extension of the Federal health planning program might bar the entry of new, potentially more efficient health care providers.

Program Accomplishments

Bureau of Health Care Delivery and Assistance

The programs of the Bureau of Health Care Delivery and Assistance assure the delivery of primary health care services to medically underserved populations; preventive health services and other specialized care to mothers and children, migrant workers and other patients; and health promotion and occupational health services to Federal employees.

Maternal and Child Health Block Grant (MCH)

The MCH Block Grant allows each State to develop its own programs and set its own practices. All 50 States, Puerto Rico, the District of Columbia, and the five insular areas have been awarded grants, and vigorous efforts continue to provide professional and technical assistance and program consultation. Guidance materials have been developed and are available for use by the States.

In FY 1986, a total of 384 projects will have been funded under the special projects set-aside authority. Of the projects funded, 117 were training projects which provided unidisciplinary and interdisciplinary MCH long-term and short-term training to health professionals. In the services research area, 46 projects were supported addressing problems in the provision of services to mothers, children and handicapped children. A total of 49 genetic projects and 25 hemophilia projects were supported providing services on a regionalized basis, and 147 demonstration projects targeted on innovative health care models for services for mothers and children were supported throughout the country.

In FY 1987, the program will fund the Block Grants to States and the special projects under the set-aside at their respective FY 1985 levels with special projects estimated to increase to 402. Particular emphasis will be placed on coordinating activities designed to accelerate the decline in infant mortality with the States.

Primary Care Block Grant

The Primary Care Block Grant, which was originally authorized by Public Law 97-35, permitted the States to assume responsibility for the operation of community health centers within their borders. The current authority prescribes certain financial and administrative restrictions that have discouraged States from exercising their option to administer this block grant.

For FY 1987, the budget incorporates an improved and expanded version of the Primary Care Block Grant. This legislation will encourage State participation and would permit each State to operate the Migrant Health, Black Lung and Family Planning centers within their borders, as well as community health centers.

During FY 1986, the Community Health Centers program will be providing access to health services for an estimated population of 5,150,000 through 550 grantees. Emphasis has continued to be placed on cost effective management assuring the provision of high quality health services through community-based organizations. Centers continue to serve high need populations in urban and rural areas. Services to new populations have been developed through expansion of existing centers and through efforts to better coordinate resources within centers.

The Black Lung Clinic program provides project grants or contracts to public and private entities for the operation of clinics which treat respiratory and pulmonary impairments in coal miners and former coal miners. In FY 1986, the program provided access to health care services to 47,500 victims of black lung disease in 38 black lung clinics.

The Migrant Health Center program provides primary health services to migrants and seasonal farmworkers and their families. In FY 1986, 500,000 migrants and seasonal farmworkers are being served by 125 Migrant Health grantees. Activities are focused on increasing the numbers of migrant and seasonal farmworkers being provided services through expansion of existing centers and coordination with local migrant related agencies.

National Health Service Corps (NHSC)

In FY 1986, the NHSC has maintained its overall growth while reducing further the number of assignees actually on the Federal payroll. Total field strength will reach 3,304 in FY 1986 but the number of Federal assignees will decrease to about 571 practitioners. These figures are the result of continued emphasis on Private Practice Options (PPO) and Private Placement Assignment (PPA) alternatives for scholarship obligors.

There are presently approximately 2,850 scholars in the pipeline in school or in training who have not yet fulfilled their service obligations. The number of scholars who were in default but who are choosing to serve under the terms of a forbearance agreement is continuing to increase. More than 65 have signed such agreements since August 1985, bringing the total number who have signed forbearance agreements or conditional service agreements to 300.

Hansen's Disease Program

In FY 1986, the Hansen's Disease Program will continue to provide health care and rehabilitative services to victims of Hansen's disease. The Gillis W. Long Hansen's Disease Center will experience about 65 new admissions and 135 readmissions and 2,300 outpatient visits during the year, while the regional contract patient care activity will provide care for about 2,300 participants. Emphasis will continue to be placed on research and on increasing cooperative research and treatment efforts with countries experiencing high levels of the disease.

Federal Employee Occupational Health (FEOH)

FY 1986 is the first year that the FEOH program is being funded entirely through reimbursements. The program has greatly expanded its array of occupational health consultative services, encompassing a more aggressive approach in developing "need based" programs at an increasing number of Federal worksites. Through the provision of an expanded volume of services, as well as a small increase in its management fees, FEOH anticipates supporting its developmental, standard setting, consultative, and operational activities within the reimbursements it generates.

Bureau of Health Professions

Over the last two decades, Federal support of the training and education of health professions and nursing students has had significant impact on the numbers, specialties and distribution of health care practitioners. Recent program emphasis has resulted in the development of training in geriatric and primary care and the achievement of minority representation and geographic distribution of health care providers.

Geriatric Health Care

In FY 1985, approximately one-third of the Bureau's programs directly addressed the needs of the elderly population. Four prototype regional Geriatric Educations Centers were supported from 1983 to 1985. These centers emphasize training of health professions faculty and personnel in day care, hospice care and home care in order to maximize the independence and mobility of the elderly. In 1985, the Bureau also supported the establishment of 16 geriatric academic administrative units to provide multidisciplinary clinical instruction and training in geriatrics to health professions faculty so that they will be able to better train students regarding the special health problems of geriatric patients.

Primary Health Care Programs

The supply of allopathic physicians in the four medical specialties comprising primary care (general practice, family practice, general internal medicine and pediatrics) increased 52.4 percent from 1970 and 1983. The supply of working nurse practitioners/midwives increased by approximately 74 percent in recent years.

Data indicate that primary care medical specialists are locating in shortage and rural areas in notably larger proportions than other medical specialists. Not only has the Bureau supported programs increasing the supply of primary care professionals, it has also had a positive impact on geographic distribution through effective program design.

Better Geographic Distribution

Studies indicate that the Area Health Education Center (AHEC) concept has had significant positive impact on the retention and availability of primary care practitioners in underserved areas. Family physicians, nurse practitioners, and physician assistants involved in AHEC projects are participants in the increased supply of health professionals in rural areas.

The AHEC program also has succeeded in attracting practitioners from racial minority groups and the disadvantaged. Special recruitment and retention programs have been developed for Native American Indian, Hispanic, and other racial minority individuals and students. When the AHEC reaches an operational stage, the State or a regional body assumes control. Currently, 15 AHECs which previously received Federal assistance are operational and receive no additional funds from this program.

Increased Total Minority Representation

The number of underrepresented minority medical students supported by the Disadvantaged Assistance program has grown by 8 percent from academic year 1982 to 1985. During this period, all underrepresented minority medical students increased by 2 percent. Data show that Disadvantaged Assistance program supported students enroll initially with lower academic credentials than non-participants, yet the retention rate of these students is slightly higher than non-program participants due to additional institutional efforts in motivation, retention and placement of minority and disadvantaged students.

The Financial Distress program has helped in maintaining accreditation or preventing the closure of four predominantly Black health professions schools. These schools have graduated approximately 40 percent of the Nation's Black physicians and dentists, 85 percent of the Black veterinarians, and 30 percent of Black pharmacists. FY 1986 is the fifth and final year for this program, as these schools have recovered their financial viability through improved management practices and increased investment of State and local resources.

Debt Management and Debt Collection

Debt Management and Collection activities are performed for health professions and nursing student loans on outstanding principal amounting to approximately $777 million. The delinquency level for health professions student loans was substantially decreased as the result of tightening of regulations concerning effective collection procedures and performance standards, site visits, and technical assistance. Performance standards for the nursing student loan program will become effective June 30, 1986. It is anticipated that these performance standards, coupled with intensive technical assistance over the past three years, will result in lowered delinquency levels.

The Health Education Assistance Loan (HEAL) program will have guaranteed an estimated $1.2 billion loans to approximately 133,000 borrowers through FY 1986. In 1986, effective collection procedures and performance standards, technical assistance provided to lenders, the imposition of a needs test and increased due diligence efforts by schools and lenders will reduce the likelihood of future HEAL defaults. Increased insurance fees (to 8 percent of the capital to be insured) and extending part of the risk to the lenders by limiting Federal insurance to 80 percent of the total loan will stabilize the Student Loan Insurance Fund in 1987.

Bureau of Health Maintenance Organizations and Resources Development

The program of the Bureau of Health Maintenance Organizations and Resources Development have accomplished many of the goals they were designed to address. As State and local governments and private sector investors have assumed greater responsibility for planning, financing and constructing health services and facilities, the role of the Bureau has become one of assuring compliance with Federal requirements and protecting Federal investments and loan guarantee liabilities.

Health Maintenance Organizations (HMOs)

Since 1971, the number of HMOs has increased from 30 to 500, and enrollment has grown from 3 million to more than 19 million. Growth between June 1984 and June 1985 was 24.9 percent, the largest growth rate recorded for the industry. Enrollment in federally qualified HMOs accounted for 3.6 million out of a total 3.8 million member increase during the year. Ninety-two HMOs in 29 States were qualified during FY 1985, bringing the total to 322 HMOs which are federally qualified and operational since the start of the program. As of September 30, 1985, 110 loans and loan guarantees totalling $219 million have been issued. No loan defaults occurred during 1985. The lack of defaults can be attributed to the growing strength of the industry, as well as to effective monitoring and technical assistance provided by the program.

The HMO industry has successfully made the transition from a largely federally supported program to one of substantial private interest and investment. Through education, ongoing communication and effective presentation of the industry by the Bureau, the investment community has enthusiastically accepted HMOs as a viable health care industry, increasing in growth and stability each year. The Federal program and the private sector have successfully worked together during this transition period in an effective partnership to promote additional HMO growth.

Resources Development (Health Facilities)

The Bureau continued its monitoring of and technical assistance to the 332 direct and guaranteed Hill-Burton loans which now total approximately $1.0 billion of unpaid balance. No new defaults occurred in FY 1985 and 2 facilities were worked out of default status. A total of 26 Hill-Burton facilities with loans totalling $258.1 million have been assisted to avoid default.

The implementation of improved recovery review procedures resulted in recoveries of almost $1.2 million in FY 1985 from health facilities which had previously received Federal construction grant assistance. Under law, the Government has the right to recover funds when the facility no longer meets the original grant criteria. There were 164 reviews conducted in FY 1985 and there were 154 cases in process as of September 30, 1985.

The Bureau continued to monitor the provisions of an estimated $500 million in uncompensated care to persons unable to pay. Health facilities which received Federal grant funds under the Hill-Burton program are obligated to provide such care on an annual basis. Under its Triennial Reporting System procedures, reporting forms were sent to over 1,250 of these facilities in FY 1985. An improved process to certify when facilities have completed their obligation was implemented and a total of 551 facilities have been so certified through FY 1985.

The Bureau monitored over 600 grants made to health professions and nurse training facilities under Titles VII and VIII of the PHS Act. Following a systematic review of all 600 grants, site visits were conducted for 75 grants that had the highest probability of non-compliance with the terms and conditions of the original grant award.

Through an agreement with the Department of Housing and Urban Development (HUD), the Bureau reviews and recommends approval of applications for loan insurance to health facilities seeking construction assistance under Section 242 of the National Housing Act. During FY 1985, 16 such applications were approved representing $792 million in insured mortgage funds. The 194 HUD loans totalling approximately $3.4 billion (unpaid balance) are continually monitored.

Resources Development (Health Planning)

The program was funded in FY 1985 under Continuing Resolution authorities. Reduced funding was appropriated in FY 1986 only to maintain activities through September 30, 1986, consistent with the Administration's eforts to reduce Federal interference in local issues and activities.

Bureau of Health Care Delivery and Assistance

	FY 1986 Appropriation	FY 1986 After Sequestration	FY 1986 Revised Estimate		FY 1987 Request		Increase or Decrease	
	Amount	Amount	FTE	Amount	FTE	Amount	FTE	Amount
I. Health Care Delivery and Assistance								
A. Maternal and Child Block Grant	$478,000,000	$457,446,000	5	$457,446,000	5	$478,000,000	—	$20,554,000
B. Primary Care:								
1. Primary Care Block Grant	—	—	—	—	—	565,100,000	—	565,100,000
2. Community Health Centers	400,000,000	396,000,000	—	375,000,000	—	—	—	-375,000,000
3. Black Lung Clinics	3,400,000	3,253,800	—	3,254,000	—	—	—	-3,254,000
4. Migrant Health	45,400,000	44,946,000	—	44,300,000	—	—	—	-44,300,000
5. Family Planning	142,500,000	136,372,500	—	136,372,500	—	—	—	-136,372,500
Subtotal, Primary Care	591,300,000	580,572,300	—	558,926,500	—	565,100,000	—	6,173,500
C. Home Health Services	1,500,000	1,435,500	—	—	—	—	—	—
D. National Health Service Corps	58,500,000	55,984,500	600	53,539,000	600	46,996,000	—	-6,543,000
E. NHSC Scholarships	2,300,000	2,201,100	—	—	—	—	—	—
F. Hansen's Disease Center	19,103,000	18,281,571	384	18,281,571	384	19,103,000	—	821,429
G. Federal Employee Occ. Hlth (Oblig)	[17,200,000]	[17,200,000]	[225]	[17,200,000]	[147]	[18,263,000]	[78]	[1,063,000]
H. Payment to Hawaii	3,300,000	3,158,100	—	2,500,000	—	2,500,000	—	—
I. Pediatric, EMS	—	—	—	—	—	—	—	—
J. AIDS	—	—	—	—	—	—	—	—
K. Direct Operations	44,289,000	42,384,573	812	42,384,573	543	29,132,000	-269	-13,252,573
Total, BHCDA	$1,198,292,000	$1,161,463,644	1,801	$1,133,077,644	1,532	$1,140,831,000	-269	$7,753,356
(Obligations)	[$1,215,492,000]	[$1,178,663,644]	[2,026]	[$1,150,277,644]	[1,679]	[$1,159,094,000]	[-347]	[$8,816,356]

1(a). Maternal and child health block grant:
Authorizing legislation--Title V of the Social Security Act.

1987 Authorization: $478,000,000

Budget Authority:

	1986 Appropriation	1986 Available after Sequestering	1987	Increase or Decrease
Budget Authority	$478,000,000	$457,446,000	$478,000,000	+$20,554,000
FTE		5	5	---

Purpose and method of operation

The Block Grant Program provides allocations to the States to provide a broad range of health services, including preventive, primary care, and rehabilitative services, to mothers and children. Funds are allocated on a pro-rata (percentage) system based on the FY 1981 program levels which were combined into the block in FY 1982. The Maternal and Child Health (MCH) Services Block Grant Program was initiated in FY 1982.

In FY 1986 after sequestration, $388,829,100 will be available for Grants to States with the remainder of $68,616,900 available for the 15% set-aside for Special Projects of Regional or National Significance (SPRANS). These funds were used to continue the on-going effort to support improved services for mothers and children, especially the reduction of infant mortality rates. A total of 384 projects were funded in FY 1986.

1987 Budget Proposal

The request of $478,000,000 will allow the program to provide services at the FY 1985 level. Availability to Grants to States will increase by $17,470,900 above the FY 1986 level for a total of $406,300,000. Also, appropriations for the SPRANS activity will increase by $3,083,100 to $71,700,000. In FY 1987, a total of 402 projects will be supported, an increase of 18 projects.

Health Care Delivery and Assistance

1(a). Maternal and child health block grant:

Estimated 1986 Funding for the 15% Set-Aside

(dollars in millions)

	1985		1986 after Sequestering		1987	
Impact Data	Amt.	Projects	Amt.	Projects	Amt.	Project
Research	6.0	51	5.7	46	6.0	47
Training	29.5	124	28.2	117	29.5	124
Hemophilia	3.6	24	3.4	25	3.6	26
Genetics	8.0	41	7.7	49	8.0	51
Other	24.6 1/	172	23.5	147	24.6	154
Total	71.7	412	68.6	384	71.7	402

1/ Includes 3 projects for the Child Prosthetic/Amputee

Health Care Delivery and Assistance

1(b). Primary care block grant:
Authorizing legislation--Titles X, XIX, Part C of the Public Health Service Act and Federal Coal Mine Health and Safety Act of 1977, Section 427(a).

1987 Authorization: $565,100,000 1/

Budget Authority:

	1986 Appropriation	1986 Available after Sequestering	1986 Revised Estimate	1987 Estimate	Increase or Decrease
Budget Authority	$591,300,000	$580,572,000	$558,926,000	$565,100,000	+$6,174,000
FTE	—	—	—	—	—

Purpose and method of operation

The purpose of the proposed and expanded Primary Care Block Grant (PCBG) is to enhance State ability to integrate services previously provided through separate categorical grant programs such as primary care services; health services for respiratory and pulmonary impairments in coal miners; health services to migrant and seasonal farmworkers and their families; and family planning services to populations in need. In FY 1987 it is proposed that funds be made available to States on a block grant basis.

During FY 1986, these services will be provided through categorical project grant programs.

The following program activities are proposed for consolidation into the Primary Care Block Grant in FY 1987:

1. Primary Care Block Grant - Community Health Centers — This activity provides essential prevention-oriented primary care services to medically underserved populations. By the end of FY 1985 primary care services were delivered to approximately 5,200,000 medically underserved persons through Community Health Center grants. Emphasis was placed on continuing projects which demonstrated good management practices and are located in areas with demonstrated high need for Federally supported primary care services. Special attention was given to the expansion of State involvement in program funding decisions. Approximately 40 State Departments of Health have entered into agreements with the Federal Government which increased State participation in the process of determining how best to utilize Federal resources within their State.

1/ New legislation is proposed for FY 1987 to consolidate the Black Lung, Migrant Health and Family Planning categorical programs with the Community Health Center/Primary Health Care block grants into the Expanded Primary Health Care Block grant and eliminate the current administrative burdens to State assumption of the Primary Care Block Grant.

1(b). Primary care block grant:

Additionally, support was provided for the costs of approximately 573 National Health Service Corps health professionals who were converted from Federal employment to become employees of the projects where they work.

During FY 1986 emphasis will continue to be placed on funding only projects which demonstrate good management practices and are located in areas with demonstrated high need for Federally supported primary care services. Priority will be given to maintaining current primary care service capacity by adjusting base operating grants to reflect cost increases. In addition, the placement of National Health Service Corps health providers as health center employees will continue. In total, 5,150,000 medically underserved persons will have access to primary care services in FY 1986. This is a decrease of 50,000 population served in FY 1985.

2. Black Lung Clinics

This activity, through project grants or contracts, assists public and private entities to establish and operate clinics which provide for the analysis, examination, and treatment of respiratory and pulmonary impairments in coal miners. These clinics reduce the incidence of high cost inpatient treatment for these conditions. In FY 1986, the program continued to provide access to health care services to 47,500 victims of black lung disease in 38 black lung clinics.

3. Migrant Health Centers

The Migrant Health Center program, through project grant authority, provides primary health services to migrants and seasonal farmworkers and their families. These services are provided in Primary Care Centers, birthing centers targeted to high risk mother and infants, and in hospitals reimbursed by Health Care Financing Administration through an interagency agreement with BHCDA, as well as insurance and limited hospitalization programs.

In FY 1986, a total of 500,000 migrants and seasonal farmworkers were served by 125 Migrant Health Program grantees, the same levels as provided for in FY 1985. The program also continued its environmental health assessment activities, and provided primary health care services through limited hospitalization and insurance procedures, as well as continued to emphasize the coordination of Federal, State and local resources to serve migrants and seasonal farmworkers and their families through the utilization of existing health resources. Program emphasis was continued to increase the capacity of the community to provide primary health services to migrants utilizing volunteers and the private sector.

4. Family Planning

This activity supports project grants for voluntary family planning projects that offer a broad range of acceptable and effective family planning methods and services including natural family planning methods and infertility services. Other program activities include grants and contracts for training of family planning services personnel, services delivery improvement research and family planning information and education.

In FY 1986 approximately 3.9 million people received family planning and infertility services through an organized delivery system of more than 4,000 clinic sites operated by health departments, hospitals, universities and other public and non-profit agencies. The priority target group for family planning services has been the 10.7 million women at risk of unplanned pregnancy; specifically those from families with income below 150 percent of poverty.

In addition to Title X (family planning) funds, service projects are supported by Maternal and Child Health Block Grant, reimbursements from Titles XIX (Medicaid) and XX (social services) of the Social Security Act, State and local governments, private donations and patient fees.

Other program activities are:

- Training - supports the development of continuing professional education programs to improve or maintain a high level of performance of clinic staff. Emphasis is on maintaining high quality, efficient and effective clinical practices and improving services for specific high risk groups.

- Service Delivery Improvement - Supports a broad range of research projects to develop and transfer effective techniques to services delivery programs. Demonstration projects and studies designed to reduce administrative burdens, improve the quality and delivery of care, and provide technical assistance and consultation are supported.

- Information and Education - Supports the development of a broad range of family planning informational and educational materials including methods of contraception, infertility and natural family planning for use by Title X projects.

1(b). Primary care block grant:

1987 Budget Proposal

The 1987 budget request provides $565,100,000 for block grant awards to the 50 States, the District of Columbia and Puerto Rico. This amount would be distributed in the same proportion as the categorical programs were in 1986. This request assumes the enactment of the proposed new legislation which would allow funds to flow through States so as to minimize Federal intervention and maximize decision making by those most knowledgeable about their region's service needs. States could assume responsibility for the Primary Care Block Grant during any quarter of FY 1987. Once a State has assumed responsibility, authority would not revert to the Federal government. Implementation of the block grant would save Federal administrative dollars. Since States would be required to submit only a basic plan and burdensome applications, reporting and monitoring would be eliminated, the Federal role would shift to one of consultation, requiring fewer persons. In addition, at the State and local program level, there would be administrative savings because delivery of primary care would not be encumbered by categorical distinctions.

Health Care Delivery and Assistance

1(b). Primary care block grant:

The following table provides output data associated with this program:

(Dollars in Millions)

I. Budget Data	1985	1986 after Sequestering	1986 Revised	1987
Budget Authority				
Primary Care Block Grant	$ .5	---	---	$565.1
Community Health Centers	382.5	$396.0	$375.0	---
Black Lung Clinics	3.3	3.3	3.3	---
Migrant Health	44.3	44.9	44.3	---
Family Planning	142.5	136.4	136.4	---
Total	$573.1	$580.6	$559.0	$565.1
II. Project Data				
Primary Care Block Grant				
Number of Grantees	1	--	52	+52 1/
Community Health Centers				
Number of Grantees	590	580	550	
Persons Served	5,200,000	5,350,000	5,150,000	
Black Lung Clinics				
Number of Clinics	38	38	38	
Service Capacity	47,500	47,500	47,500	
Migrant Health				
Number of Centers	125	125	125	
Persons served	500,000	500,000	500,000	
Family Planning				
Number of grants	89	89	89	
Number of clinics receiving Title X funds	4,000	4,000	4,000	
Number of patients served in clinics receiving Title X funds	3,900,000	3,900,000	3,900,000	

1/ Funds will be used by the States to meet their local needs.

1(c). Home health services:
Section 339 (a) and (b) of the Public Health Service Act, PL 98-555.

1987 Authorization: $7,000,000

Budget Authority:

	1986 Appropriation	1986 Available after Sequestering	1986 Revised Estimate	1987 Estimate	Increase or Decrease
Budget Authority	$1,500,000	$1,435,500	---	---	---
FTE	---	---	---	---	---

Purpose and method of operation

The Home Health Program provides grants and loans during the period of initial operation or agency expansion, for the following purposes: (1) meeting the initial costs of establishing home health agencies, (2) expanding the services available through existing agencies, and (3) training personnel. Project grants are awarded to public or non-profit private agencies and loans to proprietary entities that meet Medicare requirements for certification or agencies which intend to become certified as a medicare provider. Project grants are also awarded to public and private agencies to train paraprofessionals (including Homemaker Home Heath Aides) to provide home health services.

1987 Budget Proposal

No funds are requested for this program. The Authority to continue such program activity is contained within the Preventive Block Grant Program since 1981. It is expected the over $1.0 billion dollars provided annually to home health agencies from medicare and medicaid programs to be more than sufficient to meet home health service needs.

1(d). National health service corps:
Sections 331-338, 338C, and 338E of the Public Health Service Act expires September 30, 1984. Extension legislation is proposed for 1987.

1987 Authorization: To be proposed

Budget Authority:

	1986 Appropriation	1986 Available after Sequestering	1986 Revised Estimate	1987 Estimate	Increase or Decrease
Budget Authority	$58,500,000	$55,984,000	$53,539,000	$46,996,000	-$6,543,000
FTE			600	600	---

Purpose and method of operation

The purpose of the National Health Service Corps (NHSC) is to improve the delivery of health services in health manpower shortage areas (HMSA) and improve access to health care in these areas by the appropriate placement of health professionals and resources. As of June 30, 1985 there were 1,843 Primary Care and 777 Dental shortage areas.

The NHSC budget provides salaries and related payroll costs for federally employed health professionals as well as support costs required to assist communities in developing NHSC sites and to assign health professionals either as federally employed practitioners or as private practitioners under the Private Practice Option (PPO) and Private Placement Assignment (PPA) initiatives.

The NHSC maintains its emphasis on encouraging scholarship obligors to fulfill their obligations as private practitioners in HMSAs through the PPO or the PPA. PPO assignees are employed in non-grant funded settings located in shortage area communities which provide a sufficient economic base to support health providers as salaried employees of clinics, hospitals and group practices or as traditional fee-for-service practitioners. PPA assignees are employed as private practitioners in Community Health Centers (CHCs) or Migrant Health Centers (MHCs) where their salaries can be offset by a combination of Federal grant funds and site earnings. Under the PPA initiative, assignees are members of the NHSC, are subject to the personnel system of the entity to which they are assigned, and receive at least the same income as they would receive as Federal civil service employees of the NHSC. Employing NHSC obligors in these programs relieves the Federal government of providing direct salary support to the scholarship obligated provider and provides the health center with greater administrative control.

1(d). National health service corps:

Prime objectives of the NHSC include maintaining close contact with NHSC scholarship individuals while they are in training and, upon completion of their training, to match them to communities which are identified on the HMSA Placement Opportunity List (HPOL). The period between the initial contact with a potential NHSC assignee and the actual match of an individual to a community may span 5 to 7 years. In 1986, there are approximately 345 Federally staffed sites and 1,823 sites that are staffed by PPO and PPA health providers. In 1986, there were 1,327 obligors first available for service being placed by the NHSC, more than any other year for the program.

1987 Budget Proposal

In FY 1987, $46,996,000 is requested. This level assumes the utilization of all newly available scholarship obligors (990), the retention of 140 volunteers in the Federal field strength while maintaining the Federal field strength at 571 end-of-year positions. The combination of the Federal, PPO and PPA end-of-year field strengths will decrease slightly from 3,304 positions in 1986 to 3,292 positions in 1987 due primarily to a decrease in the number of obligors.

Experience during recent years has demonstrated the considerable difficulty in predicting the exact field strength of the NHSC; the success in placing obligors under the PPA option has resulted each year in considerable savings to the NHSC account while at the same time placing additional funding requirements on the CHC account. This problem has been solved each year through reprogramming actions from the NHSC program.

The PPO continues to be a primary NHSC priority, however, with the advent of the PPA initiative in FY 1983 the number of new PPO placements has gone through a period of decline due to an overall reduction in HMSAs. Factors contributing to the decline are the facts that many PPO obligors remain in the HMSAs upon completing their NHSC obligations and that there has been an expansion of PPA placements in existing settings and in new health centers and they have subsequently been retained in those areas. Consequently, the number of identified vacancies on the HPOL has been dramatically reduced. An exception to this decline has been those vacancies that have proven to be extremely hard to fill due primarily to the lack of social and economic factors necessary in attracting health providers.

1(d). National health service corps:

The NHSC will continue to aid in the development and staffing of free-standing sites. Efforts will continue to encourage as many scholarship obligors as possible to fulfill their obligations under the PPO. The NHSC will also be concerned with augmenting the staffing of integrated health care delivery systems under the PPA initiative by placing obligors in health manpower shortage areas as the number of identified vacancies on the HPOL will permit.

Approximately 890 new assignees will be placed in in NHSC sites in FY 1987: 113 to the Federal field strength, 50 to the PPO, and 727 to the PPA. These assignments will be in existing sites where current appointments of NHSC-placed health professionals will terminate, in new integrated or free-standing health care delivery systems or in State institutions. In addition to scholars placed in NHSC sites, approximately 100 scholars will be placed in facilities of the Indian Health Service. In addition, the extension and retention of 140 non-obligated or volunteer health providers will be permitted on a selective and priority basis. Of the 2,160 sites estimated to be staffed by NHSC providers, 345 will be staffed by Federally salaried assignees and 1,815 will utilize PPO or PPA assignees.

At the present time, the scholarship recipients who are now in the pipeline and subsequently obligated to serve will provide a sufficient base of health personnel to meet the essential staffing requirements of the Corps for the remainder of the decade.

Under the community site loan program, the governing boards of freestanding NHSC sites may be provided loans to assist them in the initial development and operation of health care facilities in which NHSC providers are being placed. A one-time loan for a maximum of $50,000 may be made to communities which do not receive health services project grant support. In FY 1985, one loan was awarded for a total of $10,000. In FY 1986, $414,000 will be available after sequestration and the proposed rescissions. In FY 1987, $500,000 is requested for making community site loans. Direct loans are made since the borrowers would normally be ineligible for loans from private sources, even at very high interest rates. The borrower is charged no interest if the loan is repaid within 5 years. Using the Average of the Interest Rates on Selected Consumer Installment Loans at Commercial Banks Reporting to the Department of the Treasury (15.875%) for the third quarter of 1985 as the benchmark rate, the average borrower receives a subsidy of $3,271.

Under the PPO loan program, NHSC scholarship recipients are provided loans to assist them to meet the cost of establishing private practices in shortage areas. In FY 1985, 39 loans, at an average of $12,741 each, were provided under this loan program for a total of $496,900. In FY 1986 and FY 1987, $500,000 will be available for this loan program. Direct loans are made since the borrowers would normally be ineligible for loans from private sources except at high interest rates. The borrower is charged 8.5% interest. During the first 24 months of the loan, the borrower must pay interest only; the loan is then repaid in monthly installments over the succeeding 36 months. Using the Average of the Interest Rates on Selected Consumer Installment Loans at Commercial Banks Reporting to the Department of the Treasury (15.875%) for the third quarter of 1985 as the benchmark rate, the average borrower receives a subsidy of $2,535.

The NHSC budget has traditionally included funds to provide for technical assistance necessary to assure that the provisions and emphasis of the Omnibus Budget Reconciliation Act, PL 97-35, are successfully implemented. In FY 1987, these efforts included the continuation of the important Federal/State cooperative activity. Participating States have been responsible for implementing major portions of the NHSC placement policy and, more importantly, identifying and developing viable sites for the placement of NHSC scholarship obligors.

As a benefit of the continued State participation in the development, validation and management of sites, the NHSC has realized significant improvements in the (1) targeting of assignees to the most hard to fill areas, (2) quality of matches between individual assignees and communities, (3) development of ties between communities and providers which increases the probability of long-term retention, and (4) overall monitoring of field activities. In FY 1986, approximately $4,500,000 will be available for the NHSC State Contract/Cooperative Agreement program representing 33 participating States. In FY 1987, an estimated $4,800,000 will provide support for 37 contracts and/or cooperative agreements, an increase of 4 States and $300,000 above levels estimated for FY 1986.

Health Care Delivery and Assistance

National health service corps:

NHSC Combined Field Strengths

NHSC Federally Employed Field Staff	1983	1984	1985	1986	1987
1. On duty start-of-year..........	1,891	1,452	747	539	517
2. (Eligible to leave)............	(1,159)	(927)	(439)	(335)	(274)
3. Estimated losses from NHSC sites	-712	-756	-289	-185	-113
4. Estimated losses due to conversion to PPO..........	-34	-53	-14	—	—
5. Estimated losses due to conversions to PP at NHSC sites.....	-19	-37	-24	—	—
6. NHSC new scholarships..........	+263	+139	+119	+217	+113
7. Other sources..................	+63	—	—	—	—
8. End-of-year Field Strength.....	1,452	747	539	571	571
Private Practice Option Field Staff					
1. On duty start-of-year..........	891	1,101	1,104	888	698
2. Estimated losses	-342	-498	-405	-377	-289
3. From new NHSC scholarships.....	+518	+448	+175	+187	+50
4. From NHSC conversion...........	+34	+53	+14	—	—
5. End-of-year PPO field strength.	1,101	1,104	888	698	459
Private Placement Field Staff					
1. On duty start-of-year..........		312	758	1,531	2,035
2. Estimated losses...............		-86	-198	-289	-500
3. From new NHSC scholarships.....	+293	+495	+947	+793	+727
4. From NHSC conversions..........	+19	+37	+24	—	—
5. End-of-year PP Field Strength..	312	758	1,531	2,035	2,262
Combined Field Strengths					
Federally employed field staff	1,452	747	539	571	571
Private practice option	1,101	1,104	888	698	459
Private placements	312	758	1,531	2,035	2,262
Combined EOY Field Strengths	2,865	2,609	2,958	3,304	3,292
Distribution of New Scholarships First Avai'able for Service					
To NHSC Federal	263	139	119	217	113
To Private Practice Option	518	448	175	187	50
To Private Placement	293	495	947	793	727
To IHS	170	209	124	130	100
Total	1,244	1,291	1,365	1,327	990

Health Care Delivery and Assistance

National health service corps:

	1985	1986 after Sequestering	1986 Revised	1987
I. **Budget Data**				
Budget Authority - Total ($000)........	$43,266	$55,984	$53,539	$46,996
Field Operation.......	(42,759)	(55,037)	(52,625)	(45,996)
Loan Funding (Section 335).......	(10)	(457)	(414)	(500)
Loan Funding (Sections 338(C)(e)(1) and 338E..........	(497)	(500)	(500)	(500)
II. **Assignee and Service Data**				
Total NHSC assignees in Federal field:	539	571	571	571
-Physicians	321	442	470	470
-Dentists	150	94	68	68
-Other	68	35	33	33
-Scholarship	397	431	431	431
-Volunteer (total)	142	140	140	140
-New Volunteers	---	---	---	---
Federal Assignments				
In rural areas	390	400	400	400
In urban areas	149	171	171	171
In 01-02 HMSAs	485	514	514	514
In 03-04 HMSAs	54	57	57	57
Sites staffed	340	345	345	345
PPO/PP Assignments	2,419	2,733	2,733	2,721
In rural areas	1,408	1,591	1,591	1,633
In urban areas	1,011	1,142	1,142	1,088
In 01-02 HMSAs	1,962	2,217	2,217	2,231
In 03-04 HMSAs	457	516	516	490
Sites staffed	1,614	1,823	1,823	1,815
Number of people served				
by Federal physicians	410,000	430,000	430,000	540,000
by PPO/PP physicians	2,115,000	2,660,000	2,660,000	3,000,000
Total people served	2,525,000	3,090,000	3,090,000	3,540,000
III. **Federal/State Cooperative Agreements**				
Number of States Participating	31	33	33	37
Total Funding	$3,910,000	$4,500,000	$4,500,000	$4,800,000

National Health Service Corps
Explanation of Change

	1986 Base		Change from Base	
	FTE	Budget Authority	FTE	Budget Authority
Increases:				
A. Built-in:				
1. Within grade increases...	600	$53,539,000	—	+$614,000
2. Increases for Federal Employee Compensation Fund, FTS, SLUC, and Service and Supply Fund..	600	53,539,000	—	+446,000
Subtotal, increases.........			—	+1,060,000
Decreases:				
A. Built-in:				
1. Non-recurring costs associated with the continued implementation of PPO and PPA placements...	600	$53,539,000	—	-$7,603,000
Subtotal, decreases.........			—	-7,603,000
Net change..................			—	-$6,543,000

1(e). National health service corps scholarships:
Sections 338A, B, D and F of the Public Health Service Act.

1987 Authorization: ---

Budget Authority:

	1986 Appropriation	1986 Available after Sequestering	1986 Revised Estimate	1987 Estimate	Increase or Decrease
Budget Authority	$2,300,000	$2,201,100	---	---	---
FTE	---	---	---	---	---

Purpose and method of operation

National Health Service Corps Scholarships provide tuition costs and monthly stipends to students in exchange for a minimum of 2 years of service as a Federal assignee of the National Health Service Corps, the Indian Health Service or as a private practitioner in a health manpower shortage area. In FY 1985, funding was provided to make 15 NHSC continuation scholarships and an additional 39 multi-year scholarship awards to former Exceptional Financial Need scholarship recipients to enable them to complete their medical education.

1987 Budget Proposal

No funds have been requested. Since the program's inception, the greatest number of scholars will be available for placement in FY 1985. Placements of scholars first available for service peaked in FY 1985 No additional NHSC scholarships are requested for physicians to locate in shortage areas since substantial growth in the overall national supply of health personnel has had a positive impact on decreasing the number of physician shortage areas. The scholarship recipients who are now in the pipeline and subsequently obligated to serve will provide a sufficient base of health personnel to meet the essential staffing requirements of the National Health Service Corps for the remainder of the decade.

Health Service Delivery and Assistance

1(f). National health service corps scholarships:

I. Budget Data	1985 Actual	1986 after Sequestering	1986 Revised	1987
Number of Continuations........	12	10	—	-10
Total $ awarded................	$240,931	$204,020	—	-$204,020
Multi-year EFN Awards..........	37	37	—	-37
Total $ awarded................	$2,026,704	$1,991,633	—	-$1,991,633
(Sophomores - 3 years)	(33)	(18)	(—)	(-18)
	(1,895,304)	(1,187,154)	(—)	(-1,187,154)
(Juniors - 2 years)	(3)	(19)	(—)	(-19)
	(121,050)	(804,479)	(—)	(-804,479)
(Seniors - 1 year)	(1)	(—)	(—)	(—)
	(10,350)	(—)	(—)	(—)
Average Annual Award Costs				
Stipend........................	$7,705	$7,934	—	
Tuition and fees...............	11,512	13,592	—	
Total average	$19,217	$21,526	—	

Discipline	FY 1985 Actual			FY 1986 after Sequestering		
	Continuations	Multi-year EFNs	Recipients 1/ Placed in 1985	Continuations	Multi-year EFNs	Recipients 1/ Available for Service
Medicine	12	34	1,322	10	33	1,298
Dentistry	—	3	25	—	4	19
VOPP	—	—	—	—	—	5
Nursing	—	—	8	—	—	5
Other	—	—	10	—	—	—
Total	12	37	1,365	10	37	1,327

1/ Includes those recipients who graduated in previous years and who have completed deferment for residency training.

Health Service Delivery and Assistance

1(f) National health service corps scholarships:

	FY 1986 Revised			1987		
Discipline	Continuations	Multi-year EFNs	Recipients 1/ Available for Service	Continuations	Multi-year EFNs	Recipients 1/ Available for Service
Medicine	—	—	1,298	—	—	977
Dentistry	—	—	19	—	—	10
VOPP	—	—	5	—	—	2
Nursing	—	—	5	—	—	1
Other	—	—	—	—	—	—
Total	—	—	1,327	—	—	990

1/ Includes those recipients who graduated in previous years and who have completed deferment for residency training.

1(f). Hansen's disease center:
Titles III and V of the Public Health Service Act.

1987 Authorization: Indefinite

Budget Authority:

	1986 Appropriation	1986 Available after Sequestering	1987	Increase or Decrease
Budget Authority	$19,103,000	$18,282,000	$19,103,000	+$821,000
FTE		384	384	---

Purpose and method of operation

This activity supports the Hansen's Disease Program which consists of: the National Hansen's Disease Center at Carville, Louisiana and contract care for Hansen's Disease patients. The National Hansen's Disease Center offers inpatient, outpatient and long term comprehensive health care for Hansen's Disease patients and conducts medical education, training, and research of national and international significance. The contract care program provides for regionalized care of Hansen's Disease patients on an interstate basis and facilitates coordination with local health agencies to assure appropriate care for Hansen's Disease patients. This program provides an effective and efficient alternative to treatment at the National Hansen's Disease Center.

In addition, funds from this account are allotted to the Centers for Disease Control (CDC) to administer payments to victims of the Tuskegee syphilis study.

In FY 1986 the Hansen's Disease Program will continue to provide health care and rehabilitative services to victims of Hansen's disease. The Gillis P. Long Hansen's Disease Center will experience about 65 new admissions and 135 readmissions and 2,300 outpatient visits during the year, while the regional contract patient care activity will provide care for about 2,300 participants. Emphasis will continue to be placed on research and on increasing cooperative research and treatment efforts internationally with countries experiencing high levels of the disease.

1987 Budget Proposal

The request of $19,103,000 provides for an increase of $821,000 over the FY 1986 funding for the continued operation of the National Hansen's Disease Center. Built-in increases of $532,000 for within-in grades, service and supply fund, and for other non-pay categories of the NHDC and Contract Patient Care programs are requested. This request also provides for program increases of $289,000 including the restoration of $258,000 to the Contract Patient Care Program, which will provide for increase in estimated participants to 2,400, and $31,000 to the CDC allotment to administer payments to the victims of the Tuskegee syphilis study.

Health Service Delivery and Assistance

1(f). Hansen's disease center:

The Contract program is expected to increase coordination between PHS and local health agencies and improve the National Hansen's Disease Control effort. Also, the funds requested would be used to continue health care to a rotating resident population of approximately 220 patients and support the existing training and research activities at Carville.

Other Information:	1985	1986 after Sequestering	1986 Revised	1987
	(Dollars in Millions)			
Program Impact Data				
Carville				
Average Daily Patient Load	220	220	220	220
Patient days	83,814	80,300	80,300	80,300
Outpatient Visits	2,300	2,300	2,300	2,300
Hanses's Disease Contract				
Patient Care:				
Number of Participants	1,300	2,300	2,300	2,400

Federal employee occupational health:
P.L. 79-658, (5 USC 7901)

1987 Authorization Indefinite:

Budget Authority:

	1986 Appropriation	1986 Available after Sequestering	1987	Increase or Decrease
Budget Authority (Obligations)	— ($17,200,000)	— ($17,200,000)	— ($18,263,000)	—— (+$1,063,000)
FTE		225	147	-78

Purpose and method of operation

The purpose of this program is to maximize Federal employee productivity and reduce Federal financial liability by (1) developing standards for Federal employee occupational health programs, (2) reviewing Federal agency plans for providing occupational health services prior to their inauguration, (3) giving advice and consultation to Federal managers in the implementation and operation of their programs, (4) evaluating Federal occupational health programs, and (5) operating occupational health programs, including employee assistance services, for Federal agencies. Standards setting, consultation services and surveys of existing health services have been supported by appropriated funds, while health programs providing occupational health services have been supported by reimbursable funds from other Federal agencies through annually renewable negotiated agreements. Operating programs include services such as: (1) health promotion and disease prevention activities including screening, health education and health counseling; (2) treatment of on-the-job illness and injury; (3) pre-employment and other special risk surveillance examinations; (4) environmental and biological monitoring; and (5) referral of employees to private physicians or dentists. This program is now operating seven Federal Employee Counseling Service Programs on a reimbursable basis for Federal agencies throughout the United States.

FY 1986 is the first year that the Federal Occupational Health (FEOH) program is being funded entirely through reimbursements. The program has greatly expanded its array of occupational health consultive services, encompassing a more aggressive approach in developing "need based" programs at an increasing Federal worksites. Through the provision of an expanded volume of services, as well as a small increase in its management fees, FEOH anticipates supporting its developmental, standard setting, and consultative, as well as operational, activities within the reimbursements it generates. These shifts in emphases will involve changes in the delivery of employee health services as well as an adjustment and expansion of the roles of FEOH staff and Federal manager.

Health Care Delivery and Assistance

Federal employee occupational health:

1987 Budget Proposal

Reimbursements are expected to increase for FY 1987 by $1,063,000 due, in most part, to the annualization of the rapid expansion of consultation services in FY 1986. This is consistent with the policy of charging agencies for the full cost of services provided by FEOH.

Efforts will be concentrated on standards setting and providing consultation services to Federal managers regarding the development, operation and evaluation of occupational health programs. The program will focus on providing occupational medicine/nursing, environmental assessment and industrial hygiene assistance, and the employee counseling assistance to managers to aid them in evaluating the quality and appropriateness of services they may provide directly or by contract.

Other Information:

	1985 Actual	1986 Estimate	1987 Estimate
Consultations	126	151	300
Number of Health Units (Reimbursable)	161	165	175
Number of Employee Assistance Programs	7	7	11
Health Promotion Services	190,534	210,000	231,000
Population Enrolled in Health Units	255,251	268,000	282,000
Clinic Visits	853,526	896,200	941,000

1(g). Payment to Hawaii:
Title III of the Public Health Service Act.

1987 Authorization: Indefinite

Budget Authority:

	1986 Appropriation	1986 Available after Sequestering	1986 Revised Estimate	1987 Estimate	Increase or Decrease
Budget Authority	$3,300,000	$3,158,000	$2,500,000	$2,500,000	---
FTE	---	---	---	---	---

Purpose and method of operation

Payments are made to the State of Hawaii to partially support the cost for care and treatment of persons with Hansen's Disease. Any expenses above the appropriated funds are borne by the State of Hawaii.

1987 Budget Proposal

The request of $2,500,000 represents approximately 61 percent of the anticipated total cost of $4,122,723 to the State of Hawaii.

Other Information: (Dollars in Millions)	1985	1986 after Sequestering	1986 Revised	1987
Average Daily Patient Load	110	110	110	110
Patient Days	40,150	40,150	40,150	40,150
Inpatient Per Diem Cost	$88.41	$93.20	$93.20	$99.19
Total Program Cost	$3,798,766	$4,004,823	$4,004,823	$4,122,723
Appropriation Requested	$2,500,000	$3,158,100	$2,500,000	$2,500,000
Percent of estimated cost supported by request	66%	79%	62%	61%

1(h). Direct operations:
Section 301 of the Public Health Service Act.

1987 Authorization: Indefinite

Budget Authority:

	1986 Appropriation	1986 Available after Sequestering	1987	Increase or Decrease
Budget Authority	$44,289,000	$42,385,000	$29,132,000	-$13,253,000
FTE		812	543	-269

Purpose and method of operation

The direct operations activity provides for the overall management, planning, direction and administration of the programs of the Bureau of Health Care Delivery and Assistance. Direct operations funds support salaries, related expenses, and other administrative activities of the Bureau. Positions and activities funded under direct operations are located in the Central Office and ten Regional Offices. The direct operations activity provides national leadership and direction as well as local technical assistance and program guidance for the administration of the Primary Care Block Grant, the Maternal and Child Health Block Grant including the set-aside for Special Projects of Regional and National Significance (SPRANS), National Health Service Corps (NHSC), NHSC Scholarships, Hansen's Disease, and the Beneficiary Medical Care program. Grants administration, data monitoring and analysis and debt collection activities are also performed under the direct operations activity.

1987 Budget Proposal

Funds are required to support staff and to meet other essential operating costs. The request includes funds for the close-out of the Migrant Health, Black Lung and Family Planning categorical grant programs and to provide assistance to States for the new expanded Primary Care Block Grant Program.

The National Health Service Corps (NHSC) program in conjunction with the NHSC scholarship program provides a national focus as the principal Federal mechanism for efforts to increase the availability and placement of health professionals for delivery of health services in the most critically underserved areas and to promote the redistribution of health care professionals to manpower shortage areas. Direct operations staff administer the NHSC and the NHSC scholarship activities, assuring the accessibility of health care in underserved areas by arranging for health professionals to provide health services in Health Manpower Shortage Areas while facilitating the integration of NHSC health providers into overall health delivery systems. Aggressive debt monitoring and collection for the costs of providing health providers to NHSC sites and for NHSC scholarship obligors in breach have been intensified and refined to insure the prompt and timely recovery of monies owed the Federal government, the proper use of program funds and to provide for the prompt and accurate billing schedules.

Health Service Delivery and Assistance

1(h). Direct operations:

Direct operations provides overall management, planning and administration for the operation of the Hansen's Disease program. The Hansen's Disease program, through its various components, will provide: 80,300 inpatient days and 2,500 outpatient visits during FY 1987; operation and direction of nationwide contract patient care through the Regional Hansen's Disease Centers (RHDC) program, which will provide for an estimated additional 1,300 out-patient visits for persons afflicted with Hansen's Disease. Also included in direct operations is the Division of Beneficiary Medical Programs, which provides operational administration of the Retirement Pay and Medical Benefits program for the PHS Commissioned Corps, retirees, and their dependents. The eligible beneficiary population for 1987 is estimated to be 30,000.

1987 Budget Proposal

In FY 1987, $29,132,000 is requested for the BHCDA direct operations account. This level reflects a net decrease of $13,253,000 below the 1986 revised estimate of $42,385,000. Under proposed legislation, the Primary Care Block Grant will be in the first year of operation in the Bureau of Health Care Delivery and Assistance. A total decrease of $14,941,000 for 269 FTEs corresponds with the close-out operations related to the consolidation of the Primary Care Block Grant and the close-out of the NHSC Scholarship and Home Health programs. These decreases are offset by built-in increases of $1,688,000 related to increases for within-grade pay and for other costs such as FTS, FECF, service and supply fund, and increased rent charges to GSA.

Direct Operations, BHCDA
Explanation of Change

	1986 Base		Change from Base	
	FTE	Budget Authority	FTE	Budget Authority
Increases:				
A. Built-in:				
1. Within grade increases...	812	$42,385,000	—	+$481,000
2. Increases for Federal Employee Compensation Fund, FTS, SLUC, and Service and Supply Fund..	—	42,385,000	—	+1,207,000
Subtotal....................			—	+1,688,000
Subtotal, increases.........	—	—	—	+$1,688,000
Decreases:				
B. Program:				
1. Program reduction associated with the implementation of the Primary Care Block Grant.............	812	42,385,000	-269	-14,941,000
Subtotal....................			-269	-14,941,000
Subtotal, decreases.........	—	—	-269	-$14,941,000
Net change..................			-269	-$13,253,000

2. Health Professions Education:
Authorizing Legislation - Titles III, IV, VII, VIII, of the Public Health Service Act

	1986 Appropriation	1986 After Sequestering	1986 Revised Estimate	1987	Increase or Decrease
(a). HP Student Assistance	$ 7,000,000	$ 6,699,000	---	---	---
(b). HP Institutional Assistance	4,600,000	4,403,000	$ 3,924,000	---	-$ 3,924,000
(c). Health Promotion/Disease Prevention	11,600,000	11,102,000	---	---	---
(d). Primary Care	66,300,000	63,449,000	18,842,000	—	-18,842,000
(e). HP Special Educational Initiatives	8,000,000	7,656,000	---	---	---
(f). Area Health Education Centers	18,000,000	17,226,000	4,743,000	---	- 4,743,000
(g). Disadvantaged Assistance	25,500,000	24,403,000	13,000,000	—	-13,000,000
(h). Health Professions Analytical Studies and Reports	2,000,000	1,914,000	1,500,000	---	- 1,500,000
(i). Nursing	63,900,000	61,152,000	8,668,000	---	- 8,668,000
(j). Direct Operations	20,200,000	19,331,000	15,040,000	$3,401,000	-11,639,000
Total Budget Authority	227,100,000	217,335,000	65,717,000	$3,401,000	-62,316,000

BEST COPY AVAILABLE

2(a.) **Health Professions Student Assistance**
Authorizing Legislation - Section 742 and 758(d) of the Public Health Service Act.

	1986 Appropriation	1986 Available after Sequestering	1986 Revised Estimate	1987	Increase or Decrease
Student loans	—	—	—	—	—
Exceptional financial need scholarships	$7,000,000	$6,699,000	—	—	—
TOTAL	7,000,000	6,699,000	—	—	—

BEST COPY AVAILABLE

Health professions student loans
(Public Health Service Act, Title VII, Section 742)

1987 Authorization:	Authorization for new loan appropriations expired September 30, 1984. Authority to continue circulation of student loan revolving funds in health professions schools expires December 31, 1991.

Budget Authority:

1986 Appropriation	1986 Available after Sequestering	1987	Increase or Decrease
---	---	---	---

Purpose and Method of Operation

The Health Professions Student Loan program authorizes long-term (ten-year), nine percent interest loans of up to $2,500 per year, plus tuition, to medical, osteopathy, dental, veterinary medicine, optometry, podiatry, and pharmacy students. Those loan funds are given to schools which in turn make awards to students that are financially needy. Current policy stipulates that medical and osteopathy students are eligible only if they demonstrate exceptional financial need. Borrowers can defer payment of health professions loans pending completion of study for advanced professional training, and for service in the Uniformed Services or Peace Corps.

1987 Budget Proposal

From 1965 through 1985 approximately $619 million, supporting an estimated 437,000 student loans, has been awarded from new loan appropriations and loan revolving funds. A substantial portion of these loan funds are being repaid to the schools and are being placed in the revolving fund for new loans to students.

In FY 1987 it is estimated that approximately 19,600 loans totalling $49,000,000 will be made to students from these revolving funds. In addition, the Health Education Assistance Loan (HEAL) program, the Guaranteed Student Loan Program (Department of Education), and other Federal, State and private loans are available sources of financial support for health professions students.

	1986 Estimate	1987 Estimate
Health Professions Student Loan Revolving Funds		
Amount available in the schools	($49,000,000)*	($49,000,000)*
Number of students assisted	19,600	19,600
Average award per student	$2,500	$2,500

* These are revolving funds from prior appropriations.

BEST COPY AVAILABLE

Health professions exceptional financial need scholarships
(Public Health Service Act, Title VII, Section 758(d))

1987 Authorization: $7,000,000

Budget Authority:

1986 Appropriation	1986 Available after Sequestering	1986 Revised Estimate	1987	Increase or Decrease
$7,000,000	$6,699,000	---	---	---

Purpose and Method of Operation

This scholarship program assists persons with exceptional financial need to enter a health professions school (medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, and pharmacy). These scholarships provide financial support for full-time students in their first-year of post-baccalaureate study. Funds are allocated to participating accredited health professions schools which in turn are responsible for selecting the students who receive the scholarships. Priority is given to schools of allopathic and osteopathic medicine, and dentistry. Recipients receive monthly stipends for living expenses, plus tuition and other reasonable educational expenses, without incurring a service obligation.

1987 Budget Proposal

In view of projected national surpluses of health professionals by the end of this decade and their improving geographic distribution, continued Federal aid for the training of health professionals is no longer required. Students are eligible to receive Health Professions Student Loan revolving funds, loans from the Health Education Assistance Loan (HEAL) program and the Guaranteed Student Loan Program (Department of Education). Furthermore, many schools have other loans and scholarships available for the financially disadvantaged student. These include State and local government programs and private endowments.

Impact Data	1985	1986 after Sequestering	1986 Revised	1987
Program amount	$7,000,000	$6,699,000	---	---
Number of recipients	421	391	---	---
Average scholarship amount	$16,627	$17,111	---	---

2(b). Health Professions Institutional Assistance:
Authorizing Legislation - Sections 788B and 788(a) of the Public
Health Service Act.

	FY 1986 Appropriation	1986 Available after Sequestering	1986 Revised Estimate	1987	Increase o Decrease
Advanced Financial Distress	$4,100,000	$3,924,000	$3,924,000	---	-$3,924,000
Two-Year Medical and Osteopathy Schools	500,000	479,000	---	---	---
TOTAL	4,600,000	4,403,000	3,924,000	---	-3,924,000

Health professions advanced financial distress
(Public Health Service Act, Title VII, Section 788B)

1987 Authorization: $3,800,000

Budget Authority:

1986 Appropriation	1986 Available after Sequestering	1987	Increase or Decrease
$4,100,000	$3,924,000	---	-$3,924,000

Purpose and Method of Operations

The Advanced Financial Distress authority, established in FY 1982, provides multi-year support to the Health Professions schools, providing financial assistance to meet incurred or prospective costs of operation to the extent essential to remove the schools from serious and long-standing financial instability. Only schools that have received at least three years of support under the (earlier) general program are eligible for Advanced Financial Distress assistance. Each school is required to have an acceptable plan to achieve financial solvency. Funds may be used to pay short-term or long-term debts, meet accreditation requirements, or meet the other costs essential to the continued operation of the institution or to the institution's achieving financial solvency. The four schools which are eligible for Advanced Financial Distress are Meharry Medical College School of Medicine, Meharry Medical College School of Dentistry, Tuskegee Institute School of Veterinary Medicine, and Xavier University College of Pharmacy.

FY 1987 Budget Proposal

Meharry Medical and Dental, Tuskegee, and Xavier have received Advanced Financial Distress Program funding since 1982. Prior to that these schools received financial aid through the regular Financial Distress program since 1972. FY 1986 provided partial support of a fifth year of funding under this plan for financial solvency.

In view of projected national surpluses of health professionals by the end of this decade and their improving geographic distribution, continued Federal aid for the training of health professionals is no longer required.

Impact Data	1985	1986 after Sequestering	1987
Meharry (Medical)..........	$2,500,000	$1,709,000	---
Meharry (Dental)...........	1,500,000	1,139,000	---
Tuskegee...................	1,200,000	697,000	---
Xavier.....................	400,000	379,000	---
Total................	$5,600,000	$3,924,000	---

Health Professions

Two-year medical and osteopathy schools
(Public Health Service Act, Title VII, Section 788a)

1987 Authorization: Combined with Health Professions Special Educational Initiatives (Section 788) which has a total authorization level of $8,000,000.

Budget Authority:

1986 Appropriation	1986 Available after Sequestering	1986 Revised Estimate	1987	Increase or Decrease
$500,000	$479,000	---	---	---

Purpose and Method of Operation

This new program provides financial assistance to two-year basic science and/or clinical medical education programs. This support is used to help these programs maintain and/or improve the quality of their educational programs.

1987 Budget Proposal

In view of projected national surpluses of health professionals by the end of this decade and their improving geographic distribution, continued Federal aid for the training of health professionals is no longer required.

Impact Data	1985	1986 after Sequestering	1986 Revised	1987
Total Program Amount	---	$479,000	---	---
Total No. of Projects		2	---	---

2(c). Health Promotion/Disease Prevention:
Authorizing Legislation - Sections 770(e), 791, 792, and 791A of the Public Health Service Act.

	1986 Appropriation	1986 Available after Sequestering	1986 Revised Estimate	1987	Increase or Decrease
Capitation	$5,000,000	$4,785,000	---	---	---
Graduate Programs in Health Administration	1,500,000	1,436,000	---	---	---
Public Health Traineeships	3,000,000	2,871,000	---	---	---
Health Administration Traineeships	500,000	479,000	---	---	---
Preventive Medicine Residencies	1,600,000	1,531,000	---	---	---
TOTAL	11,600,000	11,102,000	---	---	---

Health Professions

Public health capitation
(Public Health Service Act, Title VII, Section 770(e))

1987 Authorization: $5,125,000

Budget Authority:

1986 Appropriation	1986 Available after Sequestering	1986 Revised Estimate	1987	Increase or Decrease
$5,000,000	$4,785,000	—	—	—

Purpose and Method of Operation

Public Health Capitation grants provide Federal financial support to schools of public health to assist them in meeting the costs of their educational programs. Funds are awarded according to a formula established in the legislation; schools are required to maintain enrollment of full-time equivalent students enrolled in degree programs not less than such enrollment in school year 1983-84. Participating schools also are required to maintain the level of non-Federal expenditures existing in the previous year.

1987 Budget Proposal

In view of projected national surpluses of health professionals by the end of this decade and their improving geographic distribution, continued Federal aid for the training of health professionals is no longer required.

Impact Data	1985	1986 after Sequestering	1986 Revised	1987
Total Program Amount	$5,000,000	$4,785,000	—	—
No. of P.H. Schools	23	23	—	—
Estimated Enrollment Benefitted	7,184	7,300	—	—
Average Amount per Student	$696	$655	—	—

Graduate programs in health administration
(Public Health Service Act, Title VII, Section 791)

1987 Authorization: $1,500,000

Budget Authority:

1986 Appropriation	1986 Available after Sequestering	1986 Revised Estimate	1987	Increase or Decrease
$1,500,000	$1,436,000	---	---	---

Purpose and Method of Operation

Grants are awarded to public or nonprofit private educational entities, including schools of social work but excluding schools of public health, in order to support the expansion and improvement of graduate programs, principally in health administration, hospital administration, and health planning. To determine the amount of a grant award, the appropriation is divided by the number of approved applications from eligible schools. Eligible applicants are accredited health administration programs graduating at least twenty-five students a year, unless at least 45 percent of enrolled students are minorties in which case they may graduate twenty students a year. Eligible applicants also must expend at least $100,000 each year in funds from non-Federal sources to conduct the health administration program.

1987 Budget Proposal

The number of degree holders in health administration planning and policy analysis has increased by approximately 25 percent during the period from 1980 to 1983. Enrollments in health administration programs have also increased substantially during the last decade. Because of this no funds are requested for this program in FY 1987.

Impact Data	1985	1986 after Sequestering	1986 Revised	1987
Total Program Amount	$1,500,000	$1,436,000	---	---
No. of Awards	28	30	---	---
No. of Students Benefitted	2,100	2,250	---	---

Public health traineeships
(Public Health Service Act, Title VII, Section 792)

1987 Authorization: $3,075,000

Budget Authority:

1986 Appropriation	1986 Available after Sequestering	1986 Revised Estimate	1987	Increase or Decrease
$3,000,000	$2,871,000	---	---	---

Purpose and Method of Operation

Grants are awarded to schools of public health and other public or non-profit institutions providing graduate or specialized training in public health. The traineeships awarded by the grantee provide financial support to students for tuition and living expenses. This program supports graduate or specified training in key public health fields, e.g., biostatistics, epidemiology, dietetics, nutrition, environmental health, occupational health, health administration, health planning, health policy analysis, preventive medicine or dentistry, and maternal and child health. The current law requires 65% of the funds be awarded to students with either a baccalaureate degree or three years work experience in health services. The student also must be pursuing a course of study in one of the above public health areas.

1987 Budget Proposal

In view of projected national surpluses of health professionals by the end of this decade and their improving geographic distribution, continued Federal aid for the training of health professionals is no longer required.

Impact Data	1985	1986 after Sequestering	1986 Revised	1987
Program Amount......	$3,000,000	$2,871,000	---	---
Schools of Public Health 1/	23	23	---	---
No. of Students Supported	1,509	1,444	---	---
Average Amount per Trainee	$1,988	$1,988	---	---

1/ Awards are made to institutions on a formula basis.

Health administration traineeships
(Public Health Service Act, Title VII, Section 791A)

1987 Authorization: $500,000

Budget Authority:

1986 Appropriation	1986 Available after Sequestering	1986 Revised Estimate	1987	Increase or Decrease
$500,000	$479,000	---	---	---

Purpose and Method of Operation

Grants are awarded to public or nonprofit educational institutions, including graduate schools of social work (excluding schools of public health), to support traineeships for graduate study in accredited programs in health administration, hospital administration, or health policy analysis and planning. Programs receiving traineeship funds are located in a variety of graduate schools, including health sciences, business, and public administration. Traineeships awarded under these grants provide for stipends and other allowances. At least 80 percent of each grant must be awarded to students who have previously received a baccalaureate degree or have three years of work experience in health services.

1987 Budget Proposal

In view of projected national surpluses of health professionals by the end of this decade and their improving geographic distribution, continued Federal aid for the training of health professionals is no longer required.

Impact Data	1985	1986 after Sequestering	1986 Revised	1987
Total Program Amount	$500,000	$479,000	---	---
No. of Awards	33	33	---	---
No. of Trainees Supported	375	358	---	---
Average Amount per Trainee	$1,333	$1,333	---	---

Health Professions

Preventive medicine residencies
(Public Health Service Act, Title VII, Section 793)

1987 Authorization: $1,600,000

Budget Authority:

1986 Appropriation	1986 Available after Sequestering	1986 Revised Estimate	1987	Increase or Decrease
$1,600,000	$1,531,000	---	---	---

Purpose and Method of Operation

The Preventive Medicine Residencies program provides for increasing the national pool of health professionals with an expertise in preventive health care through grants or contracts to schools of medicine, osteopathy, and public health, to support the planning, development, and operation of physician residency training programs in preventive medicine. The program also allows financial assistance (traineeships and fellowships) to residents in such programs who plan to specialize in preventive medicine. Residency programs that provide training in general preventive medicine and preventive medicine-public health are currently receiving grant support.

1987 Budget Proposal

In view of projected national surpluses of health professionals by the end of this decade and their improving geographic distribution, continued Federal aid for the training of health professionals is no longer required.

Impact Data	1985	1986 after Sequestering	1986 Revised	1987
Program Amount	$1,600,000	$1,531,000	---	---
No.of Residency Projects/Programs	20	13	---	---
No. of Residents Benefitting	227	148	---	---

2(d). Primary Care:
Authorizing Legislation - Sections 780, 783, 784, and 786(a) of the Public Health Service Act.

1986 Appropriation	1986 Available after Sequestering	1986 Revised Estimate	1987	Increase or Decrease
Family Medicine/General Dentistry Residencies and Training				
$36,000,000	$34,452,000	$13,000,000	---	-$13,000,000
General Internal Medicine and Pediatrics				
18,500,000	17,704,000	5,842,000	---	-5,842,000
Family Medicine Departments				
7,000,000	6,699,000	---	---	---
Physician Assistants				
4,800,000	4,594,000	---	---	---
TOTAL 66,300,000	63,449,000	18,842,000	---	-18,842,000

Health Professions

Family medicine/general dentistry residencies & training
(Public Health Service Act, Title VII, Section 786)

1987 Authorization: $37,000,000

Budget Authority:

1986 Appropriation	1986 Available after Sequestering	1986 Revised Estimate	1987	Increase or Decrease
$36,000,000	$34,452,000	$13,000,000	---	-$13,000,000

Purpose and Method of Operation

Family Medicine

The Family Medicine Residencies and Training program supports grants and contracts to hospitals, schools of medicine, osteopathy, and other public or private nonprofit entities to provide a combination of allopathic residencies, osteopathic internships, faculty development, and predoctoral training in family medicine. This program also provides financial assistance for trainees in such programs who plan to specialize in the practice of family medicine.

Survey data on family practice graduates reported by the American Academy of Family Physicians in 1985 and prior years show that family practice graduates locate in geographic areas in proportion to the general population. The 1985 data indicate that approximately 50 percent have located in geographic areas of 25,000 population or less. Similar data have been reported by States.

General Dentistry

The General Dentistry Residencies and Training program supports grants to accredited schools of dentistry or post graduate dental training institutions to provide for residency programs in the general practice of dentistry. Funds may also be used to provide financial assistance for trainees.

Since the start of program assistance in 1978, 97 dental general practice residency programs have either been planned, developed, expanded or strengthened with Federal assistance. Currently, 1,298 residents have been trained in the programs receiving support. This is approximately 18 percent of all dental general practice residents graduated since 1978.

Health Professions

Family medicine/general dentistry residencies & training

1987 Budget Proposal

In view of projected national surpluses of health professionals by the end of this decade and their improving geographic distribution, continued Federal aid for the training of health professionals is no longer required.

Impact Data	1985	1986 after Sequestering	1986 Revised	1987
Family Medicine/General Dentistry				
Total Amounts	$35,950,000	$34,452,000	$13,000,000	---
FAMILY MEDICINE				
Amounts Requested	$33,950,000	$31,868,000	$12,000,000	---
Projects Supported	301	280	108	---
Distribution of Family Medicine Amounts				
Graduate				
Prog. Amount	$20,650,000	$18,553,000	$7,800,000	---
No. of Projects	189	176	76	---
No. of First-Year Intern/Residency Positions Asstd.	1,375	1,280	553	---
No. of Total Residency Positions Supported	3,945	3,673	1,586	---
Predoctoral				
Program Amount	7,200,000	6,794,700	4,200,000	---
Total Projects	63	58	32	---
No. of Grant Projects	(62)	(57)	(32)	---
No. of Contract Projects	(1)	(1)	---	---
No. of Trainees Impacted	15,320	13,850	7,907	---
Faculty Development				
Program Amount	6,100,000	6,520,300	---	---
No. of Projects	49	46	---	---
No. of Faculty Trained	2,678	2,678	---	---

Health Professions

Family medicine/general dentistry residencies & training

GENERAL DENTISTRY				
Program Amount	$2,000,000	$2,584,000	$1,000,000	---
Projects Supported	25	33	15	---
Residents Assisted	114	145	70	---

Health Professions

General internal medicine & pediatrics
(Public Health Service Act, Title VII, Section 784)

1987 Authorization: $19,500,000

Budget Authority:

1986 Appropriation	1986 Available after Sequestering	1986 Revised Estimate	1987	Increase or Decrease
$18,500,000	$17,704,000	$5,842,000	---	-$5,842,000

Purpose and Method of Operation

The General Internal Medicine and Pediatrics program, through grants and contracts to hospitals, schools of medicine, osteopathy, and other public or private nonprofit entities, supports projects to plan, develop, and operate approved residency programs in internal medicine or pediatrics. These Federal programs must emphasize ambulatory care, comprehensive health care and non-clinical areas relevant to the practitioner of general internal medicine and general pediatrics. The authority also provides financial assistance for faculty development and for traineeships and fellowships to residents who are participating in these programs, and who plan to practice general internal medicine or general pediatrics.

Approximately twenty-seven percent of competitive projects funded in FY 1985 provided substantial portions of the training opportunities in primary medical personnel shortage areas and an even greater percentage (40%) offer training experiences in settings which exemplify interdependent utilization of physicians with physicians assistants or nurse practitioners. The projects offering substantial training experiences in health manpower shortage areas have benefited minority and disadvantaged socio-economic groups where such populations exist. The presence of residents improve accessibility and availability of primary medical care. Other high national interest areas such as geriatrics also receive emphasis.

Health Professions

General internal medicine & pediatrics

1987 Budget Proposal

In view of projected national surpluses of health professionals by the end of this decade and their improving geographic distribution, continued Federal aid for the training of health professionals is no longer required.

Impact Data	1985	1986 after Sequestering	1986 Revised	1987
Total Program Amount	$18,500,000	$17,704,000	$5,842,000	—
Total Number of Projects	101	96	30	—
Graduate				
Program Amount	$18,000,000	$16,804,000	$5,842,000	—
No. of Projects	93	87	30	—
No. of First-Year Positions Supported	606	597	195	—
No. of Total Residents Assisted by this Budget	1,575	1,473	508	—
Faculty Development				
Program Amount	$500,000	$900,000	—	—
No. of Projects	8	9	—	—
No. of Faculty Trained	72	81	—	—

Family medicine departments
(Public Health Service Act, Title VII, Section 780)

1987 Authorization: $7,000,000

Budget Authority:

1986 Appropriation	1986 Available after Sequestering	1986 Revised Estimate	1987	Increase or Decrease
$7,000,000	$6,699,000	---	---	---

Purpose and Method of Operation

This program provides for grants to schools of allopathic and osteopathic medicine to establish, maintain, and/or improve academic administrative units to provide clinical instruction in family medicine. Units must be comparable to those for other major clinical specialties in status, faculty, and curriculum and must control a three-year family practice residency program or its equivalent.

1987 Budget Proposal

In view of projected national surpluses of health professionals by the end of this decade and their improving geographic distribution, continued Federal aid for the training of health professionals is no longer required.

Impact Data	1985	1986 after Sequestering	1986 Revised	1987
Program Amount	$7,500,000	$6,699,000	---	---
Total Projects	61	67	---	---
No. of New Projects	(5)	(46)	---	---
No. of Continuation Projects	(56)	(21)	---	---
Number of Individuals Participating in Supported Programs	11,590	12,730	---	---

Physician Assistants
(Public Health Service Act, Title VII, Section 783)

1987 Authorization: $4,800,000

Budget Authority:

1986 Appropriation	1986 Available after Sequestering	1986 Revised Estimate	1987	Increase or Decrease
$4,800,000	$4,594,000	---	---	---

Purpose and Method of Operation

This activity supports projects to plan, develop, operate, or maintain primary care physician assistant training programs. Awards are made through grants or contracts to schools of medicine and osteopathy, and other public or nonprofit private entities. Programs supported are required to develop and use: (1) methods designed to encourage graduates of the program to work in health personnel shortage areas; and (2) methods for placing graduates in positions for which they have been trained. Preference is given to those programs providing substantial portions of their training opportunities in health personnel shortage areas, being established in a State which does not have such a program, and conducting a program and sharing resources in conjunction with the training of primary care physicians.

Since the establishment of the physician assistant academic program in 1966, the profession has grown to an estimated 18,700 as of October 1983. Physician assistants practice in 50 States and the District of Columbia. Federal support was the primary stimulus for this accomplishment. It is estimated that between FY 1972-1985, a total of 13,117 students have graduated from federally-funded programs. Studies have shown that 47 percent of physician assistants are in communities of less than 50,000 and that 66 percent of physician assistants practice in primary care settings of which one quarter are located in communities under 10,000 population.

Health Professions

Physician Assistants

1987 Budget Proposal

The Physician Assistants program has been very successful. The Department has projected that the number of practicing physician assistants will increase to 22,100 by 1990. Because of this no funds are requested for this program in FY 1987.

Impact Data	1985	1986 after Sequestering	1986 Revised	1987
Total Program Amount	$4,800,000	$4,594,000	---	---
No. of Awards	45	44	---	---
No. of PA Trainees	1,919	1,876	---	---
No. of Contracts	1	---	---	---

2(e). Health professions special educational initiatives
(Public Health Service Act, Title VII, Section 788(b-f))

1987 Authorization: $8,000,000

Budget Authority:

1986 Appropriation	1986 Available after Sequestering	1986 Revised Estimate	1987	Increase or Decrease
$8,000,000	$7,656,000	---	---	---

Purpose and Method of Operation

The Health Professions Special Educational Initiatives program supports special high priority health professions projects of national importance. This program provides grant and contract support to health professions institutions, or other public or nonprofit private entities, for targeted health professions projects in a variety of priority areas. Students are trained to function effectively and efficiently as members of health care delivery teams and address both current and emerging health problems.

Geriatric/Long-Term Care

The Geriatric/Long-Term Care program supports the development of regional resource centers which strengthen the multidisciplinary training of primary care and other health professionals in geriatric health care. These regional resource centers train medical, osteopathic, dental, optometic, pharmacy, podiatric, nursing and relevant allied and public health faculty, students and practitioners in the diagnosis, treatment and prevention of diseases and related health care problems of the aged. In addition, they facilitate the training of health professions students and practitioners in other institutions.

Special Initiatives

This program maintains maximum flexibility through broad discretionary authority to swiftly address national problems in areas such as: (1) health promotion and disease prevention; (2) curriculum development in the organization, delivery and financing of health care; (3) economics in health professions practice and systems management; (4) clinical nutrition curriculum development; (5) competency assurance of health professionals; and (6) high priority health and health care delivery issues. The program also provides support to accredited podiatric medical schools to meet the cost to recruit students who reside in areas having shortages of podiatric personnel and to develop and operate clinical training programs in or near podiatric manpower shortage areas.

1987 Budget Proposal

In view of projected national surpluses of health professionals by the end of this decade and their improving geographic distribution, continued Federal aid for the training of health professionals is no longer required.

Impact Data	1985	1986 after Sequestering	1986 Revised	1987
Total Program Amount:	$8,000,000	$7,656,000	---	---
(Continuations).....	(2,983,200)	(6,400,000)1/	---	---
(New)...............	(5,016,800)	(1,256,000)	---	---
Total Projects:	35	30	---	---
(Continuations).....	(19)	(19)	---	---
(New)...............	(16)	(11)	---	---

1/ Includes $1,000,000 to award three grants in Podiatry Specialty Training and $5,400,000 to award 16 Geriatric/Long-Term Care continuation projects.

2(f). Area health education centers
(Public Health Service Act, Title VII, Section 781)

1987 Authorization: $18,000,000

Budget Authority:

1986 Appropriation	1986 Available after Sequestering	1986 Revised Estimate	1987	Increase or Decrease
$18,000,000	$17,226,000	$4,743,000	---	-$4,743,000

Purpose and Method of Operation

The Area Health Education Centers (AHEC) program is designed to increase the number of health practitioners in shortage areas. This program provides funds to medical and osteopathic schools for the purposes of decentralizing education by having portions of training provided in primary medical personnel shortage areas and improving the coordination and use of existing health resources. The AHEC concept is a regionalized systems approach to the development of needed health personnel. In addition, Section 781(a)(2) authorizes Federal assistance to medical and osteopathic schools which have previously received Federal financial assistance for the AHEC program under either Section 802 of P.L. 94-484 in 1979 or under Section 781. This authority provided incentives to stimulate programs responsive to regional needs such as areas related to minority recruitment and training and to geriatrics.

The AHEC program requires that 10 percent of each medical school's undergraduate clinical education occur in an AHEC center. These centers are located away from the medical school campus. AHECs also provide primary care residency training and multidisciplinary training and practice involving physicians and other health personnel. Each project contains multiple centers at different stages of development. The law also requires that AHEC programs cost-share with the Federal Government a minimum of 25 percent of the program's total cost. Federal support spans approximately six years.

1987 Budget Proposal

In view of projected national surpluses of health professionals by the end of this decade and their improving geographic distribution, continued Federal aid for the training of health professionals is no longer required.

Health Professions

2(f). Area health education centers

Impact Data	1985	1986 after Sequestering	1986 Revised	1987
Total Program Amount	$18,000,000	$17,226,000	$4,743,000	—
New AHECs	(900,000)	(254,753)	(—)	(—)
Continuation AHECs	(15,300,000)	(15,248,247)	(4,743,000)	(—)
Special Initiatives	(1,800,000)	(1,723,000)	(—)	(—)
Total Number of Projects	34	35	3	—
New AHECS	(6)	(1)	(—)	—
Continuation AHECs	(10)	(16)	(3)	(—)
Special Initiatives	(18)	(18)	(—)	(—)
Program Impact				
Students Trained	15,400	15,400	5,950	—
Counties Served	169	169	108	—
Regional Centers Supported	41	41	14	—
States Participating	14	14	3	—

2(g). Disadvantaged assistance
(Public Health Service Act, Title VII, Section 787)

1987 Authorization: $28,000,000

Budget Authority:

1986 Appropriation	1986 Available after Sequestering	1986 Revised Estimate	1987	Increase or Decrease
$25,500,000	$24,403,000	$13,000,000	---	- $13,000,000

Purpose and Method of Operation

Health Careers Opportunity Program (HCOP)

The Health Careers Opportunity Program (HCOP) helps assure that opportunities for minority and disadvantaged individuals to obtain a health professions and allied health professions education are not inappropriately limited. This program is the principal Federal program directed at increasing the numbers of underrepresented minorities and other disadvantaged individuals who are interested in pursuing a health career. Funds are awarded through grants and contracts to public and non-profit private health or educational entities to support the identification, motivation, recruitment, admissions, retention, and placement of minority and disadvantaged students. Legislation stipulates that no less than 80 percent of the funds be awarded to institutions of higher education and not more than 5 percent of such funds be awarded to institutions having the primary purpose of informing individuals about the existence and general nature of health careers.

Stipends for Disadvantaged Students of Exceptional Financial Need

Authorizing legislation directs that, of the total funds appropriated for Disadvantaged Assistance, twenty percent will be made available for stipend support for disadvantaged students of exceptional financial need who are enrolled in a school of medicine, osteopathy, or dentistry.

Health Professions

2(g). Disadvantaged assistance

Stipends up to $10,000 per student per year may be made available to minority and disadvantaged students with exceptional financial need enrolled in an eligible school of medicine, dentistry, or osteopathy. There is no obligatory service pay-back provision for students receiving these stipends. Recipients must meet part (a) of the Disadvantaged Background Definition cited in 42 CFR Part 57 of the Section 787 regulations, and the Exceptional Financial Need (EFN) eligibility criteria contained in Section 758 of the PHS Act. Eligible institutions must be a school of medicine, osteopathy, or dentistry (MOD) enrolling disadvantaged students of exceptional financial need.

1987 Budget Proposal

In view of projected national surpluses of health professionals by the end of this decade and their improving geographic distribution, continued Federal aid for the training of health professionals is no longer required.

Health Professions

2(g). Disadvantaged assistance

Impact Data	1985	1986 after Sequestering	1986 Revised Estimate	1987
Health Careers Opportunity Program (HCOP)				
Total Program Amount	$ 24,000,000	$ 19,523,000	$ 13,000,000	---
Continuation Amount	(18,600,000)	(17,248,000)	(13,000,000)	---
New Amount	(5,400,000)	(2,275,000)	(---)	---
Total No. of Projects	186	151	100	---
Continuation Projects	(135)	(133)	(100)	---
New Projects	(51)	(18)	(---)	---
Students Benefitting	27,900	22,500	15,000	---
Direct Benefitting	(11,100)	(9,000)	(6,000)	---
Indirect Benefitting	(16,800)	(13,500)	(9,000)	---
Stipends for Disadvantaged Students of EFN				
Program Amount	---	$ 4,880,000	---	---
No. of Recipients	---	488	---	---
Average Stipend Amount	---	$ 10,000	---	---

2(h). Health professions analytical studies and reports (Public Health Service Act, Titles III and VII, Sections 301, 332, and 708)

1987 Authorization: Indefinite.

Budget Authority:

1986 Appropriation	1986 Available after Sequestering	1986 Revised Estimate	1987	Increase or Decrease
$2,000,000	$1,914,000	$1,500,000	---	- $1,500,000

Purpose and Method of Operation

The Health Professions Analytical Studies and Reports program provides up-to-date, carefully analyzed information on the supply, distribution and utilization of practicing health professionals and on health professions students and institutions. This information is used by the Department, the Congress, and the private sector in making national health policy decisions. The health fields encompass over 6 million workers and over 1,700 health professions schools enrolling almost 400,000 students.

The Public Health Service Act directs the Secretary of Health and Human Services to carry out a wide variety of data collection and analytical activities through this program. For example:

- The establishment of a data system to protect the public by assisting the Secretary of DHHS to identify and exclude from Medicare/Medicaid those physicians who have been disciplined by State Medical Boards;
- monitoring of the changes and trends of physicians and other health professionals and the cost of care they provide;
- analysis and interpretation of data on: health care financing and reimbursement; geographic location of practitioners; and relationships between physicians and nonphysician health care providers;
- the collection and projection of data on the enrollments and supply of minority persons in the health professions schools and in practice;

Health Professions

2(h). Health professions analytical studies and reports

- preparation of reports to the President and Congress on the status of the health professions.

In addition, this program is charged with the responsibility for designating health professions shortage areas throughout the United States in coordination with other federal programs, the States, local communities, and professional groups.

1987 Budget Proposal

In view of projected national surpluses of health professionals by the end of this decade and their improving geographic distribution, continued Federal aid for the training of health professionals is no longer required.

Impact Data	1985	1986 after Sequestering	1986 Revised	1987
Total Program Amount	$2,000,000	$1,914,000	$1,500,000	---
Continuing Activities	(2,000,000)	(1,914,000)	(1,500,000)	(---)
New Activities	(---)	(---)	(---)	(---)
Total Projects	20	19	15	---
Continuing Activities	(20)	(19)	(15)	(---)
New Activities	(---)	(---)	(---)	(---)
Program Activities				
Health Care Costs Containment	4	4	3	---
Health Promotion/Disease Prevention	4	3	3	---
Underserved Populations	4	4	4	---
Geriatrics and Long-term Care	3	3	1	---
Minorities/Disadvantaged	2	2	2	---
Access to Health Care	3	3	2	---

2(i). **Nursing:**
Authorizing legislation - Section 301, 487, 821, 820, 822, 830, and 837 and 831(b) (as amended by the Orphan Drug Act of the Public Health Service Act)

	1986 Appropriation	1986 after Sequestering	1986 Revised Estimate	1987	Increase or Decrease
Advance Nurse Education	$16,500,000	$15,790,000	$3,719,000	---	-$3,719,000
Nurse Practitioner/Nurse Midwife	12,000,000	11,484,000	378,000	---	- 378,000
Nursing Special Projects	9,500,000	9,092,000	2,345,000	---	-2,345,000
Nurse Demonstration Projects	1,350,000	1,292,000	---	---	---
Professional Nurse Traineeships	11,500,000	11,005,000	---	---	---
Nurse Faculty Fellowships	550,000	526,000	---	---	---
Nursing Research Fellowships	2,000,000	1,914,000	733,000	---	- 733,000
Nursing Research Grants	9,700,000	9,283,000	1,493,000	---	-1,493,000
Nursing Student Loans	---	---	---	---	---
Nurse Anesthetists	800,000	766,000	---	---	---
TOTAL	63,900,000	61,152,000	8,668,000	---	-8,668,000

Advanced nurse education
(Public Health Service Act, Title VIII, Section 821)

1987 Authorization: $17,000,000

Budget Authority:

1986 Appropriation	1986 Available after Sequestering	1986 Revised Estimate	1987	Increase or Decrease
$16,500,000	$15,790,000	$3,719,000	---	-$3,719,000

Purpose and Method of Operation

The Advanced Nurse Education program provides institutional support through grants or contracts to public and nonprofit private collegiate schools of nursing to meet the costs of projects to plan, develop operate, expand, or maintain programs for the advanced training of professional nurses (master's and doctorate levels). Programs are funded which train nurses to serve as nurse educators, administrators, researchers or to serve in clinical nurse specialties determined by the Secretary to require advanced education.

1987 Budget Proposal

From 1976 through 1985 approximately $114,000,000 was made available for this program. In view of projected national surpluses of health professionals by the end of this decade and their improving geographic distribution, continued Federal aid for the training of health professionals is no longer required.

Impact Data	1985	1986 after Sequestering	1986 Revised	1987
Total Program Amt.	$16,450,000	$15,790,000	$3,719,000	---
(Continuations)	(8,383,063)	(13,056,000)	(3,719,000)	---
(New)	(8,066,937)	(2,734,000)	(---)	---
Total No. of Projects	107	91	21	---
(Continuations)	(58)	(76)	(21)	---
(New)	(49)	(15)	--	---
No. of Students Enrolled	2,200	2,000	481	---

Nurse practitioner/nurse midwife
(Public Health Service Act, Title VIII, Section 822)

1987 Authorization: $12,000,000

Budget Authority:

1986 Appropriation	1986 Available after Sequestering	1986 Revised Estimate	1987	Increase or Decrease
$12,000,000	$11,484,000	$378,000	---	-$378,000

Purpose and Method of Operation

The Nurse Practitioner and Nurse Midwife program provides grants or contracts to public or nonprofit schools of nursing, public health and medicine (which received a grant or contract under this subsection prior to October 1, 1985); public or nonprofit private hospitals; and other public or nonprofit entities to: plan, develop, operate, expand or maintain programs to educate nurse practitioners and nurse midwives. The focus of these programs is primary health care which includes: health promotion, disease prevention, basic care during acute and chronic phases of illness, guidance and counseling and referral to other health care providers when appropriate.

1987 Budget Proposal

From 1976 through 1985 approximately $111,000,000 was made available for this program. In view of projected national surpluses of health professionals by the end of this decade and their improving geographic distribution, continued Federal aid for the training of health professionals is no longer required.

Impact Data	1985	1986 after Sequestering	1986 Revised	198
Total Program Amt.	$12,000,000	$11,484,000	$378,000	---
(Continuations)	(6,978,584)	(7,200,000)	(378,000)	---
(New)	(5,021,416)	(4,284,000)	(---)	---
Total No. of Projects	69	60	2	---
(Continuations)	(39)	(39)	(2)	---
(New)	(30)	(21)	(—)	---

Nursing special projects
(Public Health Service Act, Title VIII, Section 820)

1987 Authorization: $9,500,000

Budget Authority:

1986 Appropriations	1986 Available after Sequestering	1986 Revised Estimate	1987	Increase or Decrease
$9,500,000	$9,092,000	$2,345,000	---	-$2,345,000

Purpose and Method of Operation

The objectives of the Nursing Special Project program are to improve nursing practice through increasing the knowledge and skills of nursing personnel. The nursing special project grant authority provides support to public and private entities to assist in efforts to meet the following priority areas: demonstrate improved geriatric training in preventive, acute and long term care; increasing nursing education opportunities for individuals from disadvantaged backgrounds; helping nurses to maintain existing skills and acquire new knowledge and skills through programs of continuing education; providing refresher training for nurses who wish to return to active practice; improve the supply and distribution of nurses in relation to geographic area and specialty distribution; provide career mobility for licensed practical nurses and paraprofessional nursing personnel.

1987 Budget Proposal

From 1965 through 1985 approximately $244,000,000 was made available for this program. In view of projected national surpluses of health professionals by the end of this decade and their improving geographic distribution, continued Federal aid for the training of health professionals is no longer required.

Impact Data	1985	1986 after Sequestering	1986 Revised	1987
Total Program Amt.	$9,500,000	$9,092,000	$2,345,000	---
(Continuations)	(5,642,331)	(5,058,000)	(2,345,000)	---
(New)	(3,857,669)	(4,034,000)	(---)	---
Total No. of Projects	86	72	20	---
(Continuations)	(52)	(40)	(20)	---
(New)	(34)	(32)	(---)	---

Nurse demonstration projects
(Public Health Service Act, Title VIII, Section 820)

1987 Authorization:..$2,700,000

Budget Authority:

1986 Appropriation	1986 Available after Sequestering	Revised Estimate	1987	Increase or Decrease
$1,350,000	$1,292,000	---	---	---

Purpose and Method of Operation

The broad objective of the nursing demonstration projects is to increase collaboration between nursing services and education. The authority provides support to public and private entities to: (1) demonstrate clinical nurse training programs which combine educational curricula and clinical practice in health care delivery organizations, including acute, long-term, and ambulatory care facilities; (2) improve access to nursing services in noninstitutional settings through support of nursing practice arrangements in communities; or (3) encourage nursing graduates to practice in health manpower shortage areas in order to improve specialty geographical distribution of nurses in the United States.

1987 Budget Proposal:

In view of projected national surpluses of health professionals by the end of this decade and their improving geographic distribution, continued Federal aid for the training of health professionals is no longer required.

Impact Data	1985	1986 after Sequestering	1986 Revised	1987
Program Amount	---	$1,292,000	---	---
No. of Projects	---	6	---	---

Professional nurse traineeships
(Public Health Service Act, Title VIII, Section 830)

1987 Authorization: $12,250,000

Budget Authority:

1986 Appropriation	1986 Available after Sequestering	1986 Revised Estimate	1987	Increase or Decrease
$11,500,000	$11,005,000	---	---	---

Purpose and Method of Operation

The Professional Nurse Traineeship program provides grants to eligible public or nonprofit institutions which in turn provide financial support through traineeships to registered nurses for full-time study in programs of advanced nurse education required for leadership positions as teachers, administrators/researchers, nurse practitioners/nurse midwives and clinical specialists. Special consideration is given to nurse practitioners to be nurse midwives.

1987 Budget Proposal

From 1964 through 1985 approximately $244,000,000 was made available for this program. In view of projected national surpluses of health professionals by the end of this decade and their improving geographic distribution, continued Federal aid for the training of health professionals is no longer required.

Impact Data	1985	1986 after Sequestering	1986 Revised	1987
Program Amount	$11,450,000	$11,005,000	---	---
No. of Institutions	157	157	---	---
No. of Trainees Supported	4,100	4,100	---	---
Average Amt. per Trainee	$2,804	$2,684	---	---

Nurse faculty fellowships
(Public Health Service Act, Title VIII, Section 830)

1987 Authorization: $1,100,000

Budget Authority:

1986 Appropriation	1986 Available after Sequestering	1986 Revised Estimate	1987	Increase or Decrease
$550,000	$526,000	---	---	---

Purpose and Method of Operation

The program authorizes funds to public or private nonprofit schools of nursing to cover the costs of post-baccalaureate fellowships for faculty to enable such faculty to investigate cost-effective alternatives to traditional health care modalities with special attention to the needs of at-risk populations, examine nursing interventions that result in positive outcomes in health status and address other areas of nursing practice considered by the Secretary to require additional study.

1987 Budget Proposal

In view of projected national surpluses of health professionals by the end of this decade and their improving geographic distribution, continued Federal aid for the training of health professionals is no longer required.

Impact Data	1985	1986 after Sequestering	1986 Revised	1987
Program amount	---	$526,000	---	---
No.of faculty assisted	---	526	---	---

Nursing research fellowships
(Public Health Service Act, Title IV, Section 487)

1987 Authorization: This program is authorized by the Health Research Extension Act of 1985 (P.L. 99-158) under Section 487 for National Research Service Awards, which includes programs at the National Institutes of Health and other health agencies. Total FY 1987 authorization is $260,000,000.

Budget Authority:

1986 Appropriation	1986 Available after Sequestering	1986 Revised Estimate	1987	Increase or Decrease
$2,000,000	$1,914,000	$733,000	---	-$733,000

Purpose and Method of Operation

The Nursing Research Fellowship program provides grants to individuals and institutions in support of predoctoral and postdoctoral fellowships. These awards are made to (1) prepare professional nurses to conduct independent and interdisciplinary research to extend the scientific base of nursing practice: and (2) increase the number of nurses with research training in nursing or the basic sciences to serve as faculty in basic and advanced programs of nursing education. The period of award made may not exceed five years in the aggregate for predoctoral training and three years in the aggregate for postdoctoral training.

1987 Budget Proposal

From 1964 through 1985 approximately $16,000,000 was made available for this program. In view of projected national surpluses of health professionals by the end of this decade and their improving geographic distribution, continued Federal aid for the training of health professionals is no longer required.

Impact Data	1985	1986 after Sequestering	1986 Revised	1987
Total Program Amt.	$2,000,000	$1,914,000	$733,000	---
Fellowships-Cont.	(440,747)	(1,400,616)	(606,376)	---
Fellowships-New	(1,381,934)	(313,384)	(126,624)	---
Institutional Grants	(177,319)	(200,000)	(---)	---
Total No. of Projects	167	155	70	---
Fellowships-Cont.	(56)	(124)	(58)	---
Fellowships-New	(109)	(29)	(12)	---
Institutional Grants	(2)	(2)	(---)	---

Health Professions

Nursing research grants
(Public Health Service Act, Title III, Section 301)

1987 Authorization: Open-ended authority for such sums as necessary.

Budget Authority:

1986 Appropriation	1986 Available after Sequestering	1986 Revised Estimate	1987	Increase or Decrease
$9,700,000	$9,283,000	$1,493,000	---	-$1,493,000

Purpose and Method of Operation

The Nursing Research Grants program provides grants and contracts to public and private organizations and institutions to support high quality research projects which relate to nursing practice, education, and delivery of services. Research projects focus on promoting health, well-being, and competency for personal care among all age groups; preventing health problems throughout the life span that have the potential to reduce productivity; decreasing the negative impact of health problems on coping abilities, productive life satisfaction of individuals and families; ensuring that the care needs of the particularly vulnerable are met through appropriate strategies; and designing and developing health care systems that are cost-effective in meeting the nursing needs of the population.

1987 Budget Proposal

From 1964 through 1985 approximately $86,000,000 was made available for this program. In view of projected national surpluses of health professionals by the end of this decade and their improving geographic distribution, continued Federal aid for the training of health professionals is no longer required.

Impact Data	1985	1986 after Sequestering	1986 Revised	1987
Total Program Amt.	$9,400,000	$9,283,000	$1,493,000	---
(Continuations)	(5,771,946)	(6,933,000)	(1,341,098)	---
(New)	(3,628,054)	(2,350,000)	(151,902)	---
Total No. of Projects	90	80	7	---
(Continuations)	(57)	(57)	(6)	---
(New)	(33)	(23)	(1)	---

Nursing student loans
(Public Health Service Act, Title VIII, Section 837)

1987 Authorization: Such sums as necessary to enable students who received a loan for any academic year ending before October 1, 1984 to continue or complete their education. Authority to continue circulation of student loan revolving funds in nursing schools expires December 31, 1991.

Budget Authority:

1986 Appropriation	1986 Available after Sequestering	1987	Increase or Decrease
---	---	---	---

Purpose and Method of Operation

The Nursing Student Loan program authorizes long-term (ten year), six percent interest loans of up to $2,500 per academic year or an aggregate of $10,000 to assist nursing students undertaking a course of study leading to a diploma, associate degree, bachelor's degree, or graduate degree in nursing. Funds (new capital) for this program are allocated by a legislative formula to participating accredited schools of nursing who in turn make awards to students who have a need for financial assistance.

Borrowers can defer payment of a nursing loan pending completion of study for preparation as a nurse anesthetist, for advanced professional education in nursing, and for services in the Uniformed Services or Peace Corps.

1987 Budget Proposal

No funds are requested for the Nursing Student Loan program in FY 1987. From 1965 through 1985 approximately $345 million supporting an estimated 464,000 student loans has been awarded from new loan appropriations and loan revolving funds. A substantial portion of these loan funds are now being repaid to the schools and are being placed in a revolving fund to make loans to new students. In FY 1987 it is estimated that approximately 18,000 loans will be made to nursing students from these revolving funds.

Nursing Student Loan Revolving Fund	1986 Estimate	1987 Estimate
Amount available	($18,000,000)*	($18,000,000)*
Number of students assisted	18,000	18,000
Average award per student	$1,000	$1,000

* These are revolving funds. A new appropriation is not necessary.

Nurse anesthetist program
(Public Health Service Act, Title VIII, Section 831(b))

1987 Authorization: $800,000

Budget Authority:

1986 Appropriation	1986 Available after Sequestering	1986 Revised Estimate	1987	Increase or Decrease
$800,000	$766,000	---	---	---

Purpose and Method of Operation

The Nurse Anesthetist program provides grants to public or nonprofit private institutions which in turn provide financial support through traineeships to registered nurses to become nurse anesthetists. The nurse anesthetist program requires full-time study and clinical practice of approximately 24 months to qualify the nurse for certification as a registered nurse anesthetist (CRNA).

1987 Budget Proposal

From 1984 through 1985 approximately $1,200,000 was made available for this program. In view of projected national surpluses of health professionals by the end of this decade and their improving geographic distribution, continued Federal aid for the training of health professionals is no longer required.

Impact Data	1985	1986 after Sequestering	1986 Revised	1987
Program Amt.	$800,000	$766,000	---	---
No. of Institutions	75	75	---	---
No. of Trainees Supported	600	574	---	---

2(j). Health professions direct operations:
(Public Health Service Act, Title III, Section 301):

1987 Authorization: Indefinite

Budget Authority:

	1986 Appropriation	1986 Available after Sequestering	1986 Revised Estimate	1987	Increase or Decrease
	$20,200,000	$19,331,000	$15,040,000	$3,401,000	-$11,639,000
FTE:			330	72	-258

Purpose and Method of Operation

Program support will provide funds to pay operating expenses to carry out major debt management and student assistance activites. These include the administration of: the Health Education Assistance Loan (HEAL) program; the Student Loan Insurance Fund; the Health Professions and the Nursing Student Loan Revolving Funds. This work is labor intensive and includes activites such as: due diligence monitoring, loan write-off recommendations; default recommendations; program reviews; audit reviews; and developing and maintaining policies and procedures to prevent waste, fraud, and abuse. Specific annual program operations include, but are not limited to:

-- allocating insurance guarantees;
-- processing an estimated 30,000 HEAL applications and 2,000 HEAL preclaims requests;
-- communicating with public and other governmental offices, which includes approximately 40,000 responses;
-- conducting about 140 program reviews;
-- reviewing and analyzing approximately 6,300 quarterly debt management reports and monitoring delinquency standards of health professions and nursing schools;
-- reviewing and analyzing close to 1,400 accounts of HEAL defaulters;
-- implementing new requirements in the recently enacted nursing and health professions laws which include skip-tracing authority and credit collection activities, and referral of delinquent loans;
-- responding to requests for write-offs (eg. preparing legal summaries, etc.); and
-- preparing liability statements and handling extensive correspondence with students as more programs go into a closing status.

1987 Budget Proposal

The fiscal year 1987 budget request for 72 FTEs and $3,401,000 will provide funds to pay operating expenses to carry out major debt management and student assistance activites in the health professions. These activities will help to insure that financial resources will be available to assist health professions students.

Health Professions

Health professions direct operations

	FTE	Budget Authority
1986 Appropriation..........................		$20,200,000
Decreases -Balanced Budget and Emergency Deficit Control Act (Gramm/Rudman/Hollings Amendment - 4.3% Sequester)...		- 869,000
1986 After Sequestering.....................		$19,331,000
Decreases -FY 1986 Rescission Proposal to Phase-Out Programs....................		- 4,291,000
1986 Revised Estimate.......................	330	$15,040,000
Increases +Built in Increases (Within-Grades, FTS, Service & Supply Fund, Rent, etc.......		+ 100,000
Decreases -Program Reductions.....................	-258	- 11,739,000
1987 Request................................	72	$ 3,401,000

3. Bureau of Health Maintenance Organizations and Resources Development
(Titles III, VII, and XV of the Public Health Service Act)

	1986 Appropriation	FY 1986 Available after Sequestering	1986 Revised Estimate	1987	Increase or Decrease
a.) Local Planning	$15,680,000	$15,006,000	$3,440,000	---	-$3,440,000
b.) State Planning	4,800,000	4,594,000	---	---	---
c.) Planning Methods Development	418,000	401,000	---	---	---
d.) Outpatient Facilities Cons.	5,000,000	4,785,000	$750,000	---	-$750,000
e.) Health Teaching Facilities	1,200,000	1,148,000	1,148,000	---	-1,148,000
f.) Direct Operations	20,700,000	19,810,000	18,764,000	15,628,000	-3,136,000
Total	47,798,000	45,744,000	24,102,000	15,628,000	-$8,474,000
Less User Charge Collections	---	---	---	-10,000,000	-10,000,000
Total Budget Authority	47,798,000	45,744,000	24,102,000	5,628,000	18,474,000

3(a) Local Planning and Implementation

Sections 1511 thru 1516 and 1536 of the Public Health Service Act which expired September 30, 1982. The program was funded in FY 1984, and FY 1985, under Continuing Resolutions. In FY 1986, the program was authorized by Department of Health and Human Services Appropriation, P.L. 99-178. No extension of authorization is proposed for FY 1987.

1987 Authorization: ---

Budget Authority:

FY 1986 Appropriation	1986 Available after Sequestering	1986 Revised Estimate	1987	Increase or Decrease
$15,680,000	$15,006,000	$3,440,000	---	-$3,440,000

Purpose and Method of Operation

This activity provides grants, based on a per capita formula, to local health planning bodies known as Health Systems Agencies (HSAs) which are predominately private non-profit organizations and are governed by boards representing cross sections of their communities with a majority of the members being consumers of health care services. These agencies perform a number of functions including data analyses leading to the development of long range health systems plans, the development of strategies for implementation of the plans, and making recommendations to the State Health Planning and Development Agencies on proposals for new institutional health services and facilities.

The were 141 agencies at the beginning of FY 1986, a decrease of one (1) from FY 1985. In addition, nine States and Territories receive local planning funds under Section 1536 of the PHS Act.

1987 Budget Proposal

No funds are requested in FY 1987 for local health planning. This represents a decrease of $3.4 million from the revised FY 1986 level. The Administration does not propose the extension of this program because it is inconsistent with the Administration's policy to eliminate Federal regulatory involvement in State and local health planning activities.

3(b). State Health Planning and Development

Sections 1521 and 1525 of the Public Health Service Act which expired September 30, 1982. The program was funded in FY 1984 and FY 1985 under Continuing Resolutions. In FY 1986, the program was authorized by Department of Health and Human Services Appropriation, P.L. 99-178. No extension of authorization is proposed for FY 1987.

1987 Authorization: ---

Budget Authority:

FY 1986 Appropriation	1986 Available after Sequestering	1986 Revised Estimate	1987	Increase or Decrease
$4,800,000	$4,594,000	---	---	---

Purpose and Method of Operation

The program provides grants to State Health Planning and Development Agencies (SHPDAs) based on census populations for the States. The primary responsibilities of SHPDAs are to (1) develop State health plans based on local health systems plans; (2) make decisions on proposals for new institutional health services and facilities; and (3) establish and maintain a State Health Coordinating Council (SHCC) whose members are appointed by the governors. There are 57 State Health Planning and Development Agencies.

1987 Budget Proposal

No funds are requested in FY 1987 for State Health Planning, consistent with the 1986 rescission proposal to eliminate funds for this program. The Administration does not propose the extension of this program because it is inconsistent with the Administration's policy to eliminate Federal regulatory involvement in State and local health planning activities.

3(c.) Planning Methods Development

Section 1534 of the Public Health Service Act which expired September 30, 1982. The program was funded in FY 1984 and FY 1985, under Continuing Resolutions. In FY 1986, the program was authorized by Department of Health and Human Services Appropriation, P.L. 99-178. No extension of authorization is proposed for FY 1987.

1987 Authorization: ---

Budget Authority:

FY 1986 Appropriation	1986 Available after Sequestering	1986 Revised Estimate	1987	Increase or Decrease
$418,000	$401,000	---	---	---

Purpose and Method of Operation

Funds for this activity are used to provide technical assistance to and for planning agencies by Centers for Health Planning. The Centers develop planning methods materials and hold workshops and training sessions for staff of the planning agencies. They focus a portion of their activity on consultations with agencies in solving problems of organization and planning strategies. There were two such Centers in FY 1986.

1987 Budget Proposal

No funds are requested in FY 1987 for the Centers for Health Planning, consistent with the 1986 rescissions proposal to eliminate funds for this program. The Administration does not propose the extension of this program because it is inconsistent with the Administration's policy to eliminate Federal regulatory involvement in State and local health planning activities.

3(d.) Outpatient Medical Facility Construction

Section 1610(b) of the Public Health Service Act

1987 Authority: ---

Budget Authority:

FY 1986 Appropriation	FY 1986 Available after Sequestering	1986 Revised Estimate	1987	Increase or Decrease
$5,000,000	$4,785,000	$750,000	---	-$750,000

Purpose and Method of Operation

This activity provides grants to public and non-profit private entities for construction or modernization of outpatient medical facilities which will provide services for medically underserved populations. The Department of Health and Human Services Appropriation, P.L. 99-178, provided $5,000,000 to be made available on a priority basis to facilities which have experienced a disruption in the availability of primary care services due to disasters such as hurricane, flood or fire.

1987 Budget Proposal

Since the FY 86 funds were a special one-time appropriation, no funds are requested in FY 1987 for Outpatient Medical Facility Construction. This represents a decrease of $0.75 million from the revised FY 1986 level.

3(e.) Health Teaching Facilities

Section 726 of the Public Health Service Act

1987 Authorization: Indefinite

Budget Authority:

FY 1986 Appropriation	1986 Available after Sequestering	1987	Increase or Decrease
$1,200,000	$1,148,000	---	-$1,148,000

Purpose and Method of Operation

This program continues support of the loan guarantees and interest subsidies payments for construction of health professions teaching facilities. The interest subsidy may not exceed three percent, and is paid to the lending institutions.

1987 Budget Proposal

In FY 1987 no funds are requested. Projected payments of interest subsidies on guaranteed loans will be made by carry-over monies from FY 1986. Payment of these interest subsidies is a continuing commitment of the Federal government until the year 2004, the last maturity date for these 30 year loans.

	FY 1986	FY 1987
Interest Subsidies Amount	$590,452	$572,142
Number of Lenders Receiving Interest Subsidies	3	3
Number of Schools Receiving Benefits under the Loan Guarantee Provision	3	3

3(f.) Direct Operations: Bureau of Health Maintenance Organizations and Resources Development

Section 301 of the PHS Act.

1987 Authorization. . . . . Indefinite

Budget Authority:

	FY 1986 Appropriation	1986 Available after Sequestering	1986 Revised Estimate	1987	Increase or Decrease
	$20,700,000	$19,810,000	$18,764,000	$15,628,000 1/	-$3,136,000
FTEs			364	243	-121

1/ Includes User Charge collections of $10,000,000.

Purpose and Method of Operation: This activity provides salaries and expenses to support the personnel and management operations of Health Maintenance Organizations and Resources Development staff assigned to Central and Regional Offices.

As the focal point within the Federal Government, staff assigned to the Health Maintenance Organizations (HMO) program will continue to encourage, further development of HMOs as a cost-effective alternative to more traditional forms of fee for service health care. The staff will be involved in: (1) promoting the HMO concept; (2) providing assistance to organizations seeking to develop HMOs; (3) evaluating applicants for Federal qualification as HMOs; (4) monitoring existing loans and loan guarantees awarded to qualified HMOs; (5) determining the eligibility of Competitive Medical Plans to contract with HCFA to provide care for Medicare beneficiaries; (6) monitoring qualified HMOs to assure compliance with all Federal statutory regulatory requirements; and (7) monitoring employer compliance with the mandatory offering of an HMO option. Staff will also coordinate the Department's activities with the private National Industry Council for HMO Development, which includes representatives from national professional and trade organizations, and from the investor, business, labor, and provider communities organized to stimulate the growth of an independent HMO industry.

Personnel assigned to the Resources Development (Health Facilities) Program will be used to: (1) monitor approximately $1.0 billion in outstanding health facility loans and loan guarantees with interest subsidies in order to minimize Federal default liability; (2) monitor and assist facilities receiving Federal funding to comply with assurances requirements to provide a reasonable level of uncompensated care estimated at $500 million annually to persons unable to pay; (3) administer waiver and recovery activity on grants made under Title VI and XVI ; (4) monitor over 600 grants and loan guarantees made to health education facilities under Titles VII and VIII of the PHS Act; (5) administer waiver/recapture activities on Title VII and VIII ; (6) provide interest subsidy payments for medical facilities construction loans; (7) assist in the development of departmental policy in the area of health facility utilization, planning and capital formation; and (8) provide technical assistance to health facilities on efficient design, construction, energy cost management and operation of facilities.

1987 Budget Proposal:

The costs of salaries and expenses to fund these activities will be offset, in part, by the assessment of user fees under the User Charge Statute (31 USC 9701). This statute permits such assessments when it is determined that a private benefit results from the service provided. User fees will be collected from Health Maintenance Organizations seeking federal qualification and from Competitive Medical Plans requesting determinations of eligibility to contract with the Health Care Financing Administration to provide for Medicare beneficiaries. User fees will also be collected from Hill-Burton loan and loan guarantee recipients requesting special concessions/modifications to their existing loan agreements. Appropriation language is requested to credit the HRSA appropriation with $10,000,000 derived from the user fee.

The funds requested for this activity, together with the User Fees collected provide for the performance of the following:

A continued effort to promote the HMO concept and to encourage HMO growth and development by monitoring private sector influences and coordinating public - private cooperative responses. Approximately 155 organizations are expected to apply for Federal qualification review during FY 1987. The HMO program's compliance activity will monitor 74 active operating loans. The compliance activity will monitor qualified HMOs to assure that they continue to meet the statutory and regulatory requirements of the HMO Act.

The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) authorizes compensation for services provided under the Medicare Program to eligible organizations, which are either federally qualified HMOs or Competitive Medical Plans (CMPs). The Bureau is to determine whether a prepaid plan is a CMP and eligible to contract with the Health Care Financing Administration(HFCA) under Section 1876 of the Social Security Act, as amended by TEFRA. In FY 1987, about 120 organizations are expected to apply for determinations of eligibility as CMPs to contract with HCFA to provide care for Medicare beneficiaries.

Long-term monitoring of 300 direct and federally guaranteed loans to Health Facilities for construction under Title VI and XVI of the PHS Act totaling about $1.0 billion in unpaid balances will continue. To protect federal interests, the financial conditions of these institutions will be monitored to identify financial problems which could have a negative impact and lead to default. Technical assistance has been instrumental in salvaging loans which have experienced defaults and preventing others from actual default.

Staff will continue monitoring of, and providing assistance to, health facilities which received Federal funding to comply with assurances requirements to provide a reasonable level of uncompensated care, estimated at about $500 million annually, to persons unable to pay.

Program Facts and Figures

	FTE	Amount
1986 Appropriation		$20,700,000
Sequestration		-890,000
Proposed Rescission..............		-1,046,000
1986 Current Estimate................	364	18,764,000
Increases:		
Within-grade increases.............		+ 176,000
Increase for Federal Employee Compensation Fund, FTS, SLUC, Service and Supply Fund		+ 273,000
Subtotal, increases	---	+ 449,000
Decreases:		
Program reductions.................	-121	-3,585,000
User Charge Collections in FY 1987	---	-10,000,000
Subtotal decreases	-121	-13,585,000
Net change.........................	-121	-13,136,000
FY 1987 Request	243	-5,628,000

4. Building and facilities:
Title III of the Public Health Service Act.

1987 Authorization: Indefinite

Budget Authority:

	1986 Appropriation	1986 Available after Sequestering	1987	Increase or Decrease
Budget Authority (Obligations)	$750,000 ($2,033,210)1/	$717,750 ($2,009,960)	$750,000 ($750,000)	+$32,250 (-$1,250,960)
FTE	---	---	---	---

Purpose and method of operation

This activity provides for the correction of life safety code deficiencies that exist within the National Hansen's Disease Center at Carville, Louisiana and for renovation and modernization of buildings to eliminate structural deficiencies and replace outmoded gas and sewage distribution systems. The projects are intended to assure that the facility provides a safe and functional environment for the delivery of patient care, research, and training activities.

1987 Budget Proposal

The FY 1987 request of $750,000 would provide for recurring repairs and improvements of the facilities to comply fully with applicable Federal codes and national standards at the Hansen's Disease Center. On-going repairs include painting, boiler overhaul, renovation of water, steam, and electrical and storm drainage systems. The $32,250 increase would specifically cover repair and improvements of the subsurface drainage of the dining facility.

Renovations and modernization are necessary to assure that Carville facilities are accessable to the handicapped, energy efficient and safe from hazards of fire, infection, and structural defect. The goal is to increase operational efficiency and cost effectiveness and to construct new facilities where no other economical alternative exists.

1/ Includes $1,283,210 of unobligated funds carried over from FY 1985.

5. Office of the Administrator

Program Management: Health Resources and Services Administration (Public Health Service Act, Title III, Section 301)

1987 Authorization: Indefinite

Budget Authority:

	1986 Appropriation	1986 Available after Sequestering	1986 Revised Estimate	1987	Increase or Decrease
Total	$23,994,000	$22,962,000	$18,151,000	$12,060,000	-6,091,000
FTE:			324	245	-79
(Office of the Administrator)	(15,994,000)	(15,306,000)	(14,111,000)	(8,598,000)	(-5,513,000)
			(238)	(159)	(-79)
(Facilities Engineering)	(5,000,000)	(4,785,000)	(3,640,000)	(3,640,000)	(---)
			(86)	(86)	(—)
(Organ Transplant)	(3,000,000)	(2,871,000)	(400,000)	(---)	(-400,000)
			(—)	(—)	(—)
(Improved Mgmt. of space undistributed)	(---)	(---)	(---)	(-178,000)	(-178,000)

Purpose and Method of Operations - The Health Resources and Services Program Management activity is necessary to coordinate, direct, and manage the activities of the Health Resources and Services Administration. The Office of the Administrator supports a staff necessary to plan, direct, and administer the Bureau of Health Care Delivery and Assistance, the Bureau of Health Professions, the Bureau of Health Maintenance Organizations and Resources Development, and the Indian Health Service. This activity supports two broad functions - program planning and evaluation, and administrative management, which include direct staff assistance, policy guidance, management evaluations in the areas of contracts and grant administration, financial management, personnel management, property management, legislative services, communications and public affairs and equal employment opportunity. The Program Management activity also manages the Facilities Engineering functions which were transferred to the Health Resources and Services Administration in FY 1984 and the Organ Transplant activity authorized by the National Organ Transplant Act of 1984.

1987 Budget Proposal - The 1987 budget request for $12,060,000 and 245 FTEs will maintain program direction and management services for all of the operating programs of the Health Resources and Services Administration. For the Office of the Administrator activity, the decrease of 79 FTEs and $5,513,000 is attributed to the conversion of categorical programs to the Primary Care Block Grant; elimination of the health professions and health planning programs; and elimination of other-than-permanent workyears.

For the Organ Transplant activity, the decrease of $400,000 reflects the completion of developmental work on the operation of a national network to match donor organs with recipients.

Improved management of space and services utilization, travel and training throughout the agency accounts for the decrease of $178,000.

Program Facts and Figures

	FTEs	Amount
1986 Appropriation		$23,994,000
1986 Sequester order		-1,032,000
Proposed Rescission.		-4,811,000
FY 1986 Current Estimate	324	18,151,000
Increases:		
Within-grade increases		+256,000
Increase for Federal Employees Compensation, FTS, SLUC, Service and Supply Fund		+153,000
Subtotal, increases.	---	+ 409,000
Decreases:		
Improved management of space (undistributed)		- 178,000
Program reductions	-79	- 6,322,000
Subtotal, decreases.	-79	- 6,500,000
Net Change	-79	- 6,091,000
FY 1987 Request.	245	12,060,000

MATERNAL AND CHILD HEALTH BLOCK GRANT
STATE ALLOCATIONS
Fiscal Years 1985, 1986, and 1987

	FY 1985 Actual	FY 1986 Estimate	FY 1987 Estimate
Alabama	$8,809,000	$8,430,000	$8,809,000
Alaska	845,000	809,000	845,000
Arizona	4,144,000	3,966,000	4,144,000
Arkansas	5,310,000	5,082,000	5,310,000
California	23,415,000	22,408,000	23,415,000
Colorado	5,713,000	5,467,000	5,713,000
Connecticut	3,677,000	3,519,000	3,677,000
Delaware	1,650,000	1,579,000	1,650,000
District of Columbia	6,436,000	6,159,000	6,436,000
Florida	11,913,000	11,400,000	11,913,000
Georgia	11,872,000	11,362,000	11,872,000
Hawaii	1,767,000	1,691,000	1,767,000
Idaho	2,576,000	2,465,000	2,576,000
Illinois	16,130,000	15,437,000	16,130,000
Indiana	9,377,000	8,974,000	9,377,000
Iowa	5,461,000	5,226,000	5,461,000
Kansas	3,669,000	3,511,000	3,669,000
Kentucky	8,813,000	8,434,000	8,813,000
Louisiana	9,536,000	9,126,000	9,536,000
Maine	2,856,000	2,733,000	2,856,000
Maryland	10,032,000	9,600,000	10,032,000
Massachusetts	9,178,000	8,784,000	9,178,000
Michigan	14,497,000	13,873,000	14,497,000
Minnesota	7,468,000	7,147,000	7,468,000
Mississippi	7,224,000	6,913,000	7,224,000
Missouri	9,629,000	9,215,000	9,629,000
Montana	1,897,000	1,816,000	1,897,000
Nebraska	3,307,000	3,165,000	3,307,000
Nevada	999,000	957,000	999,000
New Hampshire	1,682,000	1,610,000	1,682,000
New Jersey	8,878,000	8,496,000	8,878,000
New Mexico	2,893,000	2,768,000	2,893,000
New York	29,977,000	28,688,000	29,977,000
North Carolina	12,758,000	12,209,000	12,758,000
North Dakota	1,520,000	1,454,000	1,520,000

MATERNAL AND CHILD HEALTH BLOCK GRANT
STATE ALLOCATIONS
Fiscal Years 1985, 1986, and 1987

	1985 Actual	FY 1986 Estimate	FY 1987 Estimate
Ohio....................	17,040,000	16,308,000	17,040,000
Oklahoma................	5,229,000	5,004,000	5,229,000
Oregon..................	4,729,000	4,526,000	4,729,000
Pennsylvania............	19,092,000	18,271,000	19,092,000
Rhode Island............	1,276,000	1,221,000	1,276,000
South Carolina..........	9,032,000	8,644,000	9,032,000
South Dakota............	1,820,000	1,742,000	1,820,000
Tennessee...............	8,687,000	8,313,000	8,687,000
Texas...................	20,770,000	19,877,000	20,770,000
Utah....................	5,042,000	4,825,000	5,042,000
Vermont.................	1,459,000	1,396,000	1,459,000
Virginia................	9,747,000	9,328,000	9,747,000
Washington..............	6,574,000	6,291,000	6,574,000
West Virginia...........	5,192,000	4,969,000	5,192,000
Wisconsin...............	8,857,000	8,476,000	8,857,000
Wyoming.................	1,020,000	976,000	1,020,000
American Samoa..........	366,000	350,000	366,000
Guam....................	565,000	540,000	565,000
No Mariana Is...........	345,000	331,000	345,000
Puerto Rico.............	11,775,000	11,268,000	11,775,000
Trust Territory.........	666,000	638,000	666,000
Virgin Islands..........	1,109,000	1,062,000	1,109,000
Undistributed...........	71,700,000	68,617,000	71,700,000
Total	$478,000,000	$457,446,000[1]	$478,000,000

---

[1] Reflects a reduction of $20,554,000 pursuant to the Balanced Budget and Emergency Deficit Control Act of 1985, P.L. 99-177.

HEALTH SYSTEMS AGENCY GRANT ALLOCATIONS
FISCAL YEARS 1985, 1986 AND 1987

States	1985	1986	FY 86 Revised	1987
TOTAL	$37,514,820	$14,993,000 1/ 2/	$3,427,000 2/	---
Alabama	---	---	---	---
Alaska	420,548	68,756	---	---
Arizona	888,989	241,157	---	---
Arkansas	471,006	451,966	383,604	---
California	3,559,309	685,422	211,845	---
Colorado	86,656	---	---	---
Connecticut	633,332	295,017	57,629	---
Delaware	247,991	35,443	---	---
Dist. of Col.	124,277	36,809	---	---
Florida	---	---	---	---
Georgia	925,038	442,998	15,526	---
Hawaii	240,590	58,957	---	---
Idaho	199,424	57,603	---	---
Illinois	2,427,445	758,646	65,967	---
Indiana	---	---	---	---
Iowa	626,806	266,294	---	---
Kansas	303,491	173,628	33,917	---
Kentucky	---	---	---	---
Louisiana	---	---	---	---
Maine	---	---	---	---
Maryland	1,242,780	411,289	61,846	---
Massachusetts	1,358,126	576,122	92,603	---
Michigan	2,051,472	911,452	---	---
Minnesota	727,239	220,171	---	---
Mississippi	524,270	100,576	---	---
Missouri	---	---	---	---
Montana	173,270	31,509	---	---
Nebraska	---	---	---	---
Nevada	234,944	52,769	---	---
New Hampshire	---	---	---	---
New Jersey	1,525,889	827,080	151,955	---
New Mexico	274,789	154,472	30,136	---
New York	4,544,443	1,805,957	265,931	---
North Carolina	1,388,624	448,576	19,330	---
North Dakota	201,003	88,769	11,539	---

HEALTH SYSTEMS AGENCY GRANT ALLOCATIONS
FISCAL YEARS 1985, 1986 AND 1987

States	1985	1986	FY 86 Revised	1987
Ohio	2,219,006	1,700,147	1,442,996	---
Oklahoma	655,849	377,454	73,980	
Oregon	577,376	166,331	---	
Pennsylvania	2,335,213	1,042,760	428,358	
Rhode Island	194,769	56,354	---	
South Carolina	740,531	331,973	52,178	
South Dakota	---	---	---	
Tennessee	861,630	300,503	11,865	
Texas	---	---	---	
Utah	318,314	92,098	---	
Vermont	128,049	30,656	---	
Virginia	1,166,417	543,083	16,311	
Washington	950,093	359,242	---	
West Virginia	---	---	---	
Wisconsin	798,662	312,237	---	
Wyoming	---	---	---	
American Samoa	100,000	29,697	---	
Guam	100,000	29,697	---	
Marianas	100,000	29,697	---	
Puerto Rico	667,160	193,031	---	
Trust Territory	100,000	29,697	---	
Virgin Island	100,000	29,697	---	
Evaluation set aside	216,180	137,403	---	

1/ Reflects a reduction of $674,000 pursuant to the Balanced Budget and Emergency Deficit Control Act of 1985, P.L. 99-177.

2/ Includes the withholding of $13,000 as required by section 515 of the Treasury - Postal Services Appropriation Act of 1986.

STATE HEALTH PLANNING DEVELOPMENT AGENCY GRANT ALLOCATIONS
FISCAL YEARS 1985, 1986 AND 1987

States	1985	1986	FY 86 Revised	1987
TOTAL	$19,200,000	$4,594,000 1/	---	---
Alabama	246,896	59,070	---	---
Alaska	237,600	56,846	---	---
Arizona	237,600	56,846	---	---
Arkansas	237,600	56,846	---	---
California	1,596,931	56,846	---	---
Colorado	237,600	375,606	---	---
Connecticut	237,600	56,846	---	---
Delaware	237,600	56,846	---	---
Dist. of Col.	237,600	56,846	---	---
Florida	666,038	159,350	---	---
Georgia	357,466	85,524	---	---
Hawaii	237,600	56,846	---	---
Idaho	163,207	39,047	---	---
Illinois	716,303	171,375	---	---
Indiana	341,688	81,749	---	---
Iowa	237,600	56,846	---	---
Kansas	237,600	56,846	---	---
Kentucky	237,600	56,846	---	---
Louisiana	276,768	66,217	---	---
Maine	237,600	56,846	---	---
Maryland	268,411	64,217	---	---
Massachusetts	359,649	86,046	---	---
Michigan	565,572	135,313	---	---
Minnesota	258,434	61,830	---	---
Mississippi	237,600	56,846	---	---
Missouri	309,946	74,155	---	---
Montana	237,600	56,846	---	---
Nebraska	237,600	56,846	---	---
Nevada	237,600	56,846	---	---
New Hampshire	237,600	56,846	---	---
New Jersey	465,729	111,426	---	---
New Mexico	237,600	56,846	---	---
New York	1,101,770	263,598	---	---
North Carolina	379,293	90,746	---	---
North Dakota	237,600	56,846	---	---

STATE HEALTH PLANNING DEVELOPMENT AGENCY GRANT ALLOCATIONS FISCAL YEARS 1985, 1986 AND 1987 (cont'd.)

States	1985	1986	FY 86 Revised	1987
Ohio	670,155	160,335	---	---
Oklahoma	237,600	56,846	---	---
Oregon	237,600	56,846	---	---
Pennsylvania	741,810	177,478	---	---
Rhode Island	237,600	56,846	---	---
South Carolina	237,600	56,846	---	---
South Dakota	237,600	56,846	---	---
Tennessee	292,171	69,902	---	---
Texas	980,599	234,608	---	---
Utah	237,600	56,846	---	---
Vermont	237,600	56,846	---	---
Virginia	346,115	82,808	---	---
Washington	268,162	64,158	---	---
West Virginia	237,600	56,846	---	---
Wisconsin	296,287	70,887	---	---
Wyoming	237,600	56,846	---	---
American Samoa	95,040	22,738	---	---
Guam	95,040	22,738	---	---
Marianas	95,040	22,738	---	---
Puerto Rico	237,600	56,846	---	---
Trust Territory	95,040	22,738	---	---
Virgin Island	95,040	22,738	---	---
Evaluation set aside	192,000	46,336		

1/ Reflects a reduction of $206,000 pursuant to the Balanced Budget and Emergency Deficit Control Act of 1985, P.L. 99-177.

HEALTH RESOURCES AND SERVICES ADMINISTRATION

Estimates for Consulting Services

Account Title	Type 1/	Source of Funds 2/	1985 Actual	1986 Approp.	1986 After Sequester	1986 Revised Estimate	1987 Estimate
Evaluation:							
Health Resources and Services Administration	C	A	$3,804	$4,440	$4,263	$2,466	$2,000
Subtotal, Evaluation......................			3,804	4,440	4,263	2,466	2,000
Non-Evaluation:							
Health Resources and Services Administration	P	A	112	80	77	77	---
Health Resources and Services Administration	A	A	15	14	14	14	---
Health Resources and Services Administration	P	A	154	160	160	160	165
	A	A	39	42	42	42	45
Health Resources and Services Administration	P	A	516	500	478	260	---
Subtotal, Non-Evaluation..................			836	796	771	553	210
Total, Consulting Services................			4,640	5,236	5,034	3,019	2,210

TOTALS:

Contractual Services	3,804	4,440	4,263	2,466	2,000
Personnel appointments	782	740	715	497	165
Advisory committee expenses	54	56	56	56	45
Total, consulting services	4,640	5,236	5,034	3,019	2,210

1/ Indicate C for contractual services, P for personnel appointments, or A for advisory committee obligations.

2/ Indicate A for appropriated funds or N for non-appropriated funds.

NOTE: Narrative summary statements for consulting services follow:

Consultant Services

Evaluation

Evaluation funds in FY 1987 will be concentrated in program areas designed to improve the effectiveness and effici;ency of HRSA programs. Efforts will foxus on such activities as evaluating program efficiency standards for community/migrant health centers, on private sector support of such centers, and on use of the centers by the elderly.

Activities related to Health Professions Education and Nursing Education will not be supported due to the elimination of these programs in the FY 1987 budget request.

Program Management

The Organ Transplant Task Force will complete activities in March 1986; no consultant services are anticipated for 1987.

Bureau of Health Maintenance Organizations and Resources Development

The services procured are required to obtain a range of program review, program development and other services from sources specializing in management and development of hospitals and other health delivery facilities and particularly in capital development for these facilities. Such specialized knowledge does not exist in-house, but is required to fulfill the organizations mission regarding financing and construction of health facilities. Also, technical assistance is provided to developing and qualified Health Maintenance Organizations (HMOs). The chief vehicle for this assistance has been the Consolidated Technical Assistance Contract. Experts in all phases of HMO management are sent onsite to review the HMO and determine the source of any problem they are encountering. This assistance is essential to protect the Federal Government's investments in these organizations.

Bureau of Health Care Delivery and Assistance

Estimated costs of BHCDA Consultant Services for 1986 will be used to support the activities related to the Maternal and Child Research Grants Review Committee, the National Advisory Council on the NHSC and the National Advisory Council on Migrant Health.

Bureau of Health Professions

The FY 1986 Revised Budget level for consulting services is $260,000. This amount represents costs essential to the conduct of the Bureau's extramural program activities. These are mainly expenditures to hold National advisory Council meetings and peer review meetings for grant programs. These costs consist of honorarium, travel, and per diem administrative costs associated with conducting all meetings.

The FY 1987 level has no funds for consulting services due to the elimination of Health Professions and Nursing Programs in the FY 1987 Budget request.

HEALTH RESOURCES AND SERVICES ADMINISTRATION

Estimates for Related Services

Account Title	Type 1/	Source of Funds 2/	1985 Actual	1986 Estimate	1986 After Sequester	1986 Revised	1987 Estimate
Health Resources and Services Administration	MP	A	$ 6	$ 6	$ 6	$ 6	$ 6
	SA	A	479	440	19	421	24
Health Resources and Services Administration	MP	A	629	460	440	440	400
Health Resources and Services Administration	MP	A	---	1	1	1	1
Health Resources and Services Administration	MP	A	236	300	287	100	200
	SA	A	1,599	2,000	1,914	1,500	---
Total Related Services....................			2,949	3,207	2,667	2,468	631

TOTALS:

Management and professional services......	871	767	734	547	607
Special studies and analyses..............	2,078	2,440	1,933	1,921	24
Management and support services for research and development activities......	---	---	---	---	---
Total, related services.................	2,949	3,207	2,667	2,468	631

1/ Indicate MP for management and professional services, SA for special studies and analyses, or RD for management and support services for research and development activities.

2/ Indicate A for appropriated funds or N for non-appropriated funds.

NOTE: Narrative summary statements for related services follow:

Related Services

Program Management

Obligations for related services continue to decline due to budget constraints and the completion of the Organ Transplant Task Force.

Bureau of Health Maintenance Organizations and Resource Development

Obligations for related services continue to decline due to budget constraints and the proposed phase-out of a major program activity.

Bureau of Health Care Delivery and Assistance

Estimated costs of BHCDA Related Services for 1986 will be used to support the activities related to the Maternal and Child Research Grants Review Committee, the National Advisory Council on the NHSC and the National Advisory Council on Migrant Health.

Bureau of Health Professions

The FY 1986 level for related services is $1,600,000. These services and activities provide up-to-date, analyzed information on the supply, distribution and utilization of practicing health professionals; and health professions students and institutions. This information is essential to the Department, the Congress, and the private sector in considering, developing and implementing national health policy decisions. The health fields encompass over 6 million workers and over 1,700 health professions schools enrolling almost 400,000 students.

This Bureau is also charged with the responsibility for properly identifying, designating, de-designating, and reviewing health professions shortage areas throughout the United States in coordination with other Department programs, the States, local communities, and professional groups. This analytical activity is designed to provide needed information and comprehensive analysis of data collected which is not provided through other sources such as the National Center for Health Statistics, Bureau of Census, States, and professional associations.

The major program within the Bureau of Health Professions requiring the use of related services is Health Professions Analytical Studies and Reports. The Health Education Assistance Loan (HEAL) program has an annual agreement with the Department of Education to perform computer services on student and lender information. A debt Management and collection contract is usually awarded annually for technical assistance to institutions on the fiscal accountability of the student assistance programs.

The FY 1987 level has no funds for relating services in the category of special studies and analyses due to the elimination of the Health Professions Analytical Studies and Reports program in the 1987 Budget. Management and Professional Services will be completed in FY 1987 at a reduced level.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
HEALTH RESOURCES AND SERVICES ADMINISTRATION

Detail of Permanent Positions

7560350	1985 Actual	1986 Estimate	1987 Estimate
ES-5	2	2	1
ES-4	9	11	7
ES-3	2	1	---
Subtotal	13	14	8
GS/GM-15	102	99	64
GS/GM-14	346	344	247
GS-13	509	516	341
GS-12	291	383	176
GS-11	170	162	95
GS-10	7	7	6
GS-9	331	336	129
GS-8	33	33	24
GS-7	170	168	123
GS-6	192	198	134
GS-5	147	147	96
GS-4	87	86	58
GS-3	12	13	14
GS-2	11	10	8
Subtotal	2,408	2,404	1,515

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
HEALTH RESOURCES AND SERVICES ADMINISTRATION

Detail of Permanent Positions

	1985 Actual	1986 Estimate	1987 Estimate
Commissioned Officer:			
CO-8	2	2	2
CO-7	2	2	2
CO-6	147	143	84
CO-5	152	149	103
CO-4	175	162	127
CO-3	234	224	223
CO-2	4	7	7
CO-1	---	---	---
Subtotal	716	689	548
Ungraded	107	107	107
Total Permanent Positions	3,244	3,214	2,178
Unfilled positions, end of year	306	179	---
Total Permanent Employment, end of year	2,938	3,035	2,178

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH RESOURCES AND SERVICES ADMINISTRATION

Medical Facilities Guarantee and Loan

FY 1987 Budget .... Page

Appropriation language 142

Amounts available for obligation 143

Summary of changes 144

Budget Authority by Activity 145

Budget Authority by Object 145

Authorization legislation 145

Table of estimates and appropriations 146

Justification:

Narrative:
1. General Statement 147
2. Activities
    Interest Subsidies 148

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH RESOURCES AND SERVICES

Medical Facilities Guarantee and Loan Fund

Federal Interest Subsidies for Medical Facilities

For carrying out subsections (d) and (e) of section 1602 of the Public Health Service Act, [$25,000,000] *$20,000,000* together with any amounts received by the Secretary in connection with loans and loan guarantees under title VI of the Public Health Service Act, to be available without fiscal year limitation for the payment of interest subsidies. During the fiscal year no commitments for direct loans, or loan guarantees shall be made. *(Department of Health and Human Services Appropriation Act, 1986.)*

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH RESOURCES AND SERVICES ADMINISTRATION

Medical Facilities Guarantee and Loan Fund

Amounts Available for Obligation

	1985 Actual	1986 Current Estimate	1987 Estimate
Appropriation	$26,500,000	$25,000,000	$20,000,000
Receipts and reimbursements from: Non-Federal sources	19,652,000	16,529,000	16,350,000
Unobligated balance, start of year	49,399,000	46,967,000	43,721,000
Unobligated balance, end of year	-46,967,000	-43,721,000	-36,533,000
Total, obligations	$48,584,000	$44,775,000	$43,538,000

144

Summary of Changes

1986 Current Estimate, Budget Authority	$25,000,000
(Obligations)	($44,775,000)
1987 Estimated Budget Authority	$20,000,000
(Obligations)	($43,538,000)
Net Change Budget Authority	-$5,000,000
(Obligations)	(-$1,237,000)

	1986 Base Amount	Change from Base Amount
Increases		
Built-in:		
1. Principal payments to FFB	$ 5,793,000	+$ 345,000
Total Increases		+$ 345,000
Decreases		
Built in:		
1. Interest subsidies on guaranteed loans	27,000,000	-1,582,000
2. Interest expense paid to FFB	9,682,000	-582,000
Total Decreases		-$1,582,000
Net Change		-$1,237,000

Budget Authority by Activity

	1985 Actual	1986 Current Estimate	1987 Estimate
Other Services .... (Principal pymts. to FFB)	(9,137,000)	($5,793,000)	($6,138,000)
Investments and loans	($1,811,000)	($2,300,000)	($2,300,000)
Grants subsidies & contributions	26,500,000	25,000,000	20,000,000
(obligations)	(26,884,000)	(27,000,000)	(26,000,000)
Interest & dividends	(10,752,000)	(9,682,000)	(9,100,000)
Total Budget Authority	$26,500,000	$25,000,000	$20,000,000
(obligations)	(48,584,000)	(44,775,000)	(43,538,000)

Budget Authority by Object

	1986 Current Estimate	1987 Estimate	Increase or Decrease
Other Services	($5,793,000)	($6,138,000)	(+$345,000)
Investments and loans (obligations)	(2,300,000)	(2,300,000)	(---)
Grants subsidies and contributions	25,000,000	20,000,000	-5,000,000
(obligations)	(27,000,000)	(26,000,000)	(-1,000,000)
Interest and dividends	(9,682,000)	(9,100,000)	(- 582,000)
Total Budget Authority by Object	$25,000,000	$23,000,000	-$5,000,000
(obligations)	(44,775,000)	(43,538,000)	(-1,237,000)

Authorizing Legislation

	1986 Amount Authorized	1986 Enacted	1987 Amount Authorized	1987 Budget Estimate
I. Interest subsidies:				
(a) PHS Act, Section 1602(c)(3)(ii)	Indefinite	$25,000,000	Indefinite	$20,000,000

Medical Facilities Guarantee and Loan Fund

Year	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
1973	$ 2,500,000	$ 2,500,000	$ 2,500,000	$ 2,500,000
1974	---	---	---	---
1975	---	---	---	---
1976	10,000,000	10,000,000	10,000,000	10,000,000
1977	31,000,000	31,000,000	31,000,000	31,000,000
1978	41,000,000	41,000,000	41,000,000	41,000,000
1979	42,000,000	42,000,000	42,000,000	42,000,000
1980	45,000,000	45,000,000	45,000,000	45,000,000
1981	---	---	---	---
1982	35,000,000	30,000,000	22,000,000	22,000,000
1983	32,000,000	32,000,000	32,000,000	32,000,000
1984	32,000,000	32,000,000	32,000,000	32,000,000
1985	26,500,000	26,500,000	26,500,000	26,500,000
1986	25,000,000	25,000,000	25,000,000	25,000,000
1987	20,000,000			

Medical Facilities Guarantee and Loan Fund
Public Health Service Act, Title XVI

Budget Authority:

1986 Current Estimate	1987 Estimate	Increase or Decrease
$25,000,000	$20,000,000	-$5,000,000

General Statement

The Medical Facilities Guarantee and Loan Fund was established in 1972 under the Medical Facilities Construction Program in order to make funds available for construction of medical facilities. This was accomplished either by making direct loans or providing guarantees on loans by third parties and paying interest subsidies on guaranteed loans or direct loans sold to the Federal Financing Bank. The fund is established in the Treasury without fiscal year limitation to make direct loans, pay interest subsidies, make payments of principal and interest in the event default on a guaranteed loan, and repurchase loans sold and guaranteed.

The fund currently consists of 1) a direct loan account containing approximately $4.9 million which was originally established at $30 million as a revolving fund for use in making direct loans (no loans have been made or sold from this account since 1977); 2) a default account containing approximately $38.1 million originally established at $50 million and used for payment of defaults; 3) an interest subsidy account, containing approximately $3.9 million at the end of FY 1985, which is replenished by appropriation and used for payment of interest subsidies on guaranteed loans and interest costs on loans which are sold to FFB with a guarantee.

In FY 1987, $20 million is requested in new budget authority to pay interest subsidies. In addition, approximately $7.0 million, which includes prior year unobligated funds in the interest subsidy account and repayments of principal and interest in the direct loan account, will be used to provide the $27.0 million required for interest subsidies. It is estimated that $2.3 million will be required from the default account to pay principal payments on defaulted guaranteed loans.

Interest Subsidies (Medical Facilities Guarantee and Loan Fund)
Public Health Service Act, Section 1602(c)(3)(ii)

Budget Authority:

1986 Current Estimate	1985 Estimate	Increase or Decrease
$25,000,000	$20,000,000	-$5,000,000

1987 Authorization.......................Indefinite

Purpose and method of operation - The purpose of the interest subsidy activity is to honor commitments entered into for subsidizing interest payments on guaranteed loans made for modernization, construction, and conversion of hospitals and other non-profit medical facilities. Interest is subsidized at the rate of 3% on guaranteed loans made by private lenders and in the case of direct loans sold to the Federal Financing Bank, the amount of interest paid from the fund is based on the rate paid by the borrower and the rate given by FFB.

1987 Budget Proposal - There is a requirement of $27.0 million to meet commitments for interest subsidies due on loans as required by the Public Health Service Act as amended. The $20 million of new budget authority requested for 1987 will be used for these subsidies along with approximately $7.0 million in unobligated funds available in the Interest Subsidy and Direct Loan accounts.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH RESOURCES AND SERVICES ADMINISTRATION

Health Maintenance Organization
Loan and Loan Guarantee Fund

FY 1987 Budget — Page

Appropriation Language 150

Amounts available for obligation 151

Summary of changes 152

Obligations by Activity 153

Obligations by Object 153

Authorizing Legislation 154

Table of estimates and appropriations 155

Justification:

Narrative:

1. General Statement 156
2. Loan and Loan Guarantee Program 157

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH RESOURCES AND SERVICES

Health Maintenance Organization Loan and Loan Guarantee Fund

[Any amounts received by the Secretary in connection with loans and loan guarantees under title XIII of the Public Health Service Act, and not to exceed $700,000, may be disbursed with respect to any liability or contingent liability incurred prior to 1985.]

Health Maintenance Organizations Loan and Loan Guarantee Fund

Amounts Available for Obligation

	1985 Actual	1986 Current Estimate	1987 Estimate
Appropriation	$1,720,000	---	---
Receipts and Reimbursements from: Non-Federal sources	$14,954,000	$16,567,000	$16,696,000
Off-Budget Entities	2,940,000	700,000	---
Unobligated balance, start of year	4,677,000	6,803,000	7,370,000
Unobligated balance, end of year	-6,803,000	-7,370,000	-8,116,000
Total obligations	$17,488,000	$16,700,000	$15,950,000

Summary of Changes

1986 Estimated Obligations	$16,700,000
1987 Estimated Obligations	$15,950,000
Net Change	-$750,000

	1986 Base		Change from Base	
	Pos.	Amount	Pos.	Amount
1. Interest disbursements to FFB	---	$11,425,000	---	-$500,000
2. Principal disbursements to FFB	---	4,432,000	---	+450,000
3. Guaranteed Loan repurchases from private banks	---	143,000	---	---
4. Direct Loans	---	700,000	---	-700,000
Net change				-$750,000

Obligations by Activity

	1985 Actual		1986 Current Estimate		1987 Estimate	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Interest disbursements to FFB	---	$ 9,536,000	---	$11,425,000	---	$10,925,000
Principal disbursements to FFB	---	6,955,000	---	4,432,000	---	4,882,000
Disbursement for Guarantee claims	---	143,000	---	143,000	---	143,000
Direct Loans	---	854,000	---	700,000	---	---
Total obligations by Activity	---	$17,488,000	---	$16,700,000	---	$15,950,000

Obligations by Object

	1986 Current Estimate	1987 Estimate	Increase or Decrease
Other Services (Principal Pymts to FFB)	$ 4,432,000	$ 4,882,000	+$450,000
Investments and Loans	700,000	---	-700,000
Grants and Subsidies	143,000	143,000	---
Interest and dividends	11,425,000	10,925,000	-500,000
Total Obligations by Object	$16,700,000	$15,950,000	-$750,000

Authorizing Legislation

	1986 Amount Authorized	1986 Amount Enacted	1987 Amount Authorized	1987* Budget Estimate
1. Loan and Loan Guarantee Fund (a) Public Health Service Act (Secs. 1308 and 1309)	Indefinite	---	Indefinite	---

* Such sums as may be necessary to meet the obligations of the loan fund resulting from defaults and to maintain a balance to continue revolving the fund and provide a margin for anticipated losses may be requested under a supplemental appropriation at the end of each Calendar Year.

Health Maintenance Organizations Loan and Loan Guarantee Fund

Year	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
1975	$50,000,000	$35,000,000	$35,000,000	$35,000,000 1/
1982	17,500,000	17,500,000	17,500,000	17,500,000 2/
1983	2,650,000	2,650,000	2,650,000	2,650,000 2/
1984	---	---	---	---
1985	1,720,000	1,720,000	1,720,000	1,720,000 2/
1986	---	---	---	---
1987	---			

1/ Funds were appropriated as capital for the revolving fund.

2/ Funds were used to repurchase defaulted notes.

Health Maintenance Organizations Loan and Loan Guarantee Fund
Title XIII of the Public Health Service Act

	1986 Current Estimate	1987 Estimate	Increase or Decrease
Loan and Loan Guarantee Fund Obligations	$16,700,000	$15,950,000	-$750,000

General Statement

The HMO Loan and Loan Guarantee Fund was established as a revolving fund in 1975 with an appropriation of $35 million to the Department as capital for the fund. Direct loans and loan guarantees were made to public and non-profit Health Maintenance Organizations to cover initial operating deficits. As direct loans are made they are sold to the Federal Financing Bank, thereby providing a continuous source of loan capital.

In 1987, no new operating loans or disbursements on previous loan commitments will be made.

Health Maintenance Organizations Loan and Loan Guarantee Fund

Authorizing Legislation - Title XIII of the Public Health Service Act

	1986 Current Estimate	1987 Estimate	Increase or Decrease
Obligations	$16,700,000	$15,950,000	-$750,000
Budget Authority	---	---	---

1986 Authorization......................Indefinite

Purpose and Method of Operation - The HMO Loan and Loan Guarantee Fund was established as a revolving fund in 1975 with an appropriation of $35 million as capital for the fund. The HMO Loan and Loan Guarantee Fund serves as a mechanism to provide working capital during the initial operating period of an HMO when financial deficits are expected. Direct loans, as made, are sold to the Federal Financing Bank, thereby providing a continuous source of loan capital.

1987 Budget Proposal

In Fiscal Year 1987, the HMO Loan Program projects no further disbursements on new or previously committed loans. A supplemental appropriation may be requested at a later date to cover any defaults occuring in calendar year 1986.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH RESOURCES AND SERVICES ADMINISTRATION

Health Professions Graduate Student Loans and Insurance Program

Fiscal Year 1987 Budget

Page No.

Amounts available for obligation........................ 160

Summary of changes.. 160

Budget authority by activity.............................. 161

Budget authority by object................................ 162

Authorizing legislation................................... 163

Tables of estimates and appropriations.................... 164

Justification:

1. Narrative:

A. General Statement................................ 165

B. Activity:
Health professions graduate student loan and insurance program (Health education assistance loans and Student loan insurance fund).......... 166

Health Professions Graduate Student Loans and Insurance Program (HEAL)

Amounts Available for Obligation

	1985	1986	1987
Appropriation......................	--	--	--
Borrowing authority...............	--	--	--
Subtotal, budget authority......	--	--	--
Receipts: Insurance premiums 1/...	$12,957,659	$20,000,000	$ 8,000,000
Interest on U.S. Securities	566,788	670,000	410,000
Repayments of loans.....	140,130	200,000	300,000
Unobligated balance, start of year:			
Student Loan Insurance Fund balance	1,306,897	1,328,233	3,198,233
U.S. Securities.................	4,000,000	9,000,000	10,000,000
Unobligated balance, end of year:			
Student Loan Insurance Fund balance	-1,328,233	-3,198,233	-1,408,233
U.S. Securities.................	-9,000,000	-10,000,000	-1,500,000
Total, obligations 2/.............	$ 8,643,241	$18,000,000	$19,000,000

1/ Insurance premium charges received from borrowers on loans insured. Premium rate: FY 1985 is 2%; FY 1986 - from 10/1/85 to 7/22/86 is 2%, from 7/23/86 to 9/30/86 is estimated to be 8%; FY 1987 is 8% (estimate).

2/ Payments from Student Loan Insurance Fund on defaults, death, and disability claims.

Summary of Changes

1986 Estimated loan guarantees	$ 275,000,000 1/
1987 Estimated loan guarantees	100,000,000 2/
Net change	$-175,000,000

1/ Excludes carryover loan guarantee authority of $114,000,000.

2/ Appropriation language for the loan guarantee ceiling is provided in the Health Resources and Services Administration appropriation language.

Health Professions Graduate Student Loans and Insurance Program

Budget Authority by Activity

	1985 Actual Amount	1986 Estimate Amount	1987 Estimate Amount
Capital Investments 1/	--	--	--
(obligations)	(8,331,761)	($17,400,000)	($18,350,000)
Death and Disability Claims 2/	--	--	--
(obligations)	(311,480)	(600,000)	(650,000)
Total budget authority 3/	--	--	--
(obligations)	($8,643,241)	($18,000,000)	($19,000,000)

1/ Default payments paid from Student Loan Insurance Fund (SLIF).

2/ Payments from SLIF made on death and disability claims.

3/ Total payments made from SLIF.

Health Professions Graduate Student Loans and Insurance Program

Budget Authority by Object

	1986 Estimate	1987 Estimate	Increase or Decrease
Investments and loans [1/]	$17,400,000	$18,350,000	$ +950,000
Insurance claims and indemnities [2/]	600,000	650,000	+50,000
Total budget authority by object (obligations)	-- ($18,000,000)	-- ($19,000,000)	-- ($+1,000,000)

[1/] Payments from Student Loan Insurance Fund (SLIF) on defaulted loans.

[2/] Payments from SLIF on death and disability claims.

Health Professions Graduate Student Loans and Insurance Program

Authorizing Legislation

	1986 Authorized	1986 Estimate	1987 Authorized	1987 Estimate
Public Health Service Act:				
Health education assistance loans and Insurance Fund: (Title VII, part C, subpart I)				
Appropriation 1/......	Indefinite	--	Indefinite	--
Borrowing authority 2/........	Indefinite	--	Indefinite	--

1/ Authorized under Sec. 727(b)(2) of the PHS Act. "...for fiscal years after September 30, 1978 such sums as necessary for the purpose of administering this subpart. Sums appropriated under this subsection shall remain available until expended..."

2/ Authorized under Sec. 734(a) and (b) of the PHS Act. "There is hereby established a student loan insurance fund which shall be available without fiscal year limitation..." "If at any time, the monies in the fund are insufficient to make payments in connection with the default of any loan insured by the Secretary under this subpart, the Secretary is authorized to issue to the Secretary of the Treasury notes or other obligations in such forms and denominations, bearing such maturities, and subject to such terms and conditions as prescribed by the Secretary with the approval of the Secretary of the Treasury, but only in such amounts as may be specified from time to time in appropriation Acts."

Health Professions Graduate Student Loans and Insurance Program

Year	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
Borrowing Authority:				
1979	$5,000,000	$5,000,000	$2,500,000	$2,500,000 1/
1980	--	--	--	--
1981	--	--	--	--
1982	--	--	--	--
1983	--	--	--	--
1984	--	--	--	--
1985	--	--	--	--
1986	--	--	--	--
1986 Sequester	--	--	--	--
1986 Proposed Rescission	--	--	--	--
1987	--	--	--	--

1/ Unused "no-year" borrowing authority as authorized under Section 734(a) and (b) of the Public Health Service Act.

Justification

Health Professions Graduate Student Loans and Insurance Program

	1986 Estimate	1987 Estimate	Increase or Decrease
Health education assistance loans and Insurance Fund: Borrowing authority, Total budget authority.......	--	--	--
(Obligations)..................	18,000,000	19,000,000	+1,000,000 1/

1/ Represents increased payments from the Student Loan Insurance Fund.

General Statement

Health Professions Graduate Student Loans (Health Education Assistance Loans)

To assist in training students in various health fields, a Health Education Assistance Loan Program (HEAL) was authorized to provide insured loans for graduate students in schools of allopathic and osteopathic medicine, dentistry, veterinary medicine, optometry, podiatry, public health, pharmacy, chiropractic, or graduate programs in health administration and clinical psychology.

Eligible borrowers obtain loan funds to be used for educational expenses and reasonable living expenses. Loan principal will be provided by commercial lenders, educational institutions, State agencies, insurance companies and pension funds. The principal and interest will be insured by the Federal Government.

Student Loan Insurance Fund

The Health Professions Graduate Student Loan Insurance Fund (SLIF) provides payments for defaulted loans, death and disability claims of student borrowers. Deposits to the fund are derived from insurance premiums paid by the borrowers, investment income, and defaulted loan collections.

Health professions graduate student loans and insurance program
(Public Health Service Act, Title VII, Section 727 and 734)

1987 Authorization: (Loan Limitation - $290,000,000) No Federal funds are required. Private capital from banks, credit unions, State agencies, etc. is used to finance these loans.

Budget Authority:

1986 Appropriation	1986 Available after Sequestering	1987	Increase or Decrease
($275,000,000) 1/	($275,000,000) 1/	($100,000,000)	(-$175,000,000)

1/ Excludes $114,000,000 loan guarantee authority carried over from prior years.

Purpose and Method of Operation

Health Professions Graduate Student Loans

The Health Education Assistance Loan (HEAL) program insures loans provided by non-Federal lenders to students in the health professions schools. Principal and interest are insured by the Federal Government. Students may borrow up to $20,000 a year - to an aggregate total of $80,000 (except for pharmacy, chiropractic, public health, health administration, allied health and clinical psychology students who are limited to $12,500 a year and a total $50,000). The maximum allowable interest rate (which is determined quarterly) is the prior calendar quarter auction rate for 91-day Treasury bills, plus 3 percent, rounded to the next highest 1/8th of one percent. Student borrowers are not required to begin repayment of the principal until 9 months after they complete training and have a maximum repayment period of 25 years. Payment of principal and interest may be deferred during additional periods of full-time study and for up to 4 years for internship or residency training, and for up to 3 years service in the armed forces, the Peace Corps or other specified program as a full-time volunteer or in the National Health Service Corps.

Student Loan Insurance Fund (SLIF)

The Student Loan Insurance Fund (SLIF) is established with monies derived from an insurance premium charged to student borrowers who secure HEAL Loans. The insurance premium, not to exceed 8 percent per year of the loan principal, will be charged to lenders who in turn charge the premium to the borrower. Payments are made from the Student Loan Insurance Fund for defaults, bankruptcy, death, and disability of borrowers. Deposits to the fund are also derived from loan collections from defaulted borrowers and from appropriations. Funds not needed for current operations of the SLIF may be invested in bonds or other obligations guaranteed as to principal and interest by the United States. Profits from these investments are deposited in the SLIF.

Health Professions

Health professions graduate student loans and insurance program

---

1987 Budget Proposal

Appropriation:

It is not anticipated that an appropriation will be required in FY 1987 to cover an estimated $19,000,000 for repayment of loans due to death and disability, bankruptcy and default claims. Receipts from insurance premiums will be available to cover anticipated FY 1987 costs.

New Guarantee Authority:

The guarantee authority of the Federal Government will have insured over $1.2 billion in loan amounts between Fiscal Years 1979 and 1986. Using Federal guarantees during FY 1987 private lending institutions will make loans totalling $100 million to 10,000 students. A lower Federal loan limitation is proposed in 1987 to limit the potential draw down on the SLIF resulting from an increased number of claims. Additionally it is proposed through FY 1987 appropriation language to (1) limit loan guarantee authority to $100,000,000; (2) have lenders assume the risk of loss on account of death or permanent and total disability of a borrower and allow lenders to charge a credit life insurance fee to the borrower; and (3) have lenders assume 20% of the loss resulting from default by the borrower on any Health Education Assistance Loan.

Impact Data	1985	1986 Available after Sequestering	1987
Amount of new loan guarantee authority	$271,000,000 1/	$389,000,000 2/	$100,000,000
Number of borrowers	27,374	39,292	10,000
Average amount per borrower	$9,900	$9,900	$10,000
Loan disbursements to students	$271,000,000	$389,000,000	$100,000,000

1/ Includes $21,000,000 carryover loan guarantee authority from prior years.
2/ Includes $114,000,000 carryover loan guarantee authority from prior years.

BLANK PAGE

THURSDAY, MARCH 6, 1986.

ALCOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION

ST. ELIZABETH'S HOSPITAL

WITNESSES

ROBERT L. TRACHTENBERG, ACTING ADMINISTRATOR

CHARLES SCHUSTER, DIRECTOR, NATIONAL INSTITUTE ON DRUG ABUSE

LORAN ARCHER, ACTING DIRECTOR, NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM

DENNIS WILLIAMS, BUDGET OFFICER, DEPARTMENT OF HEALTH AND HUMAN SERVICES

KENT AUGUSTSON, BUDGET OFFICER, ALCOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION

SHERVERT FRAZIER, DIRECTOR, NATIONAL INSTITUTE OF MENTAL HEALTH

EDWARD GOODY, BUDGET OFFICER, NATIONAL INSTITUTE OF MENTAL HEALTH

DR. PRESCOTT, SUPERINTENDENT, ST. ELIZABETH'S HOSPITAL

JAMES PITTMAN, ASSISTANT DIRECTOR, ST. ELIZABETH'S HOSPITAL

Mr. NATCHER. The committee will come to order. At this time we take up the budget request for the Alcohol, Drug Abuse and Mental Health Administration, and also St. Elizabeth's Hospital.

We have before the committee Mr. Robert L. Trachtenberg, the Acting Administrator. We are delighted to have you before the committee at this time.

And before you give us your statement, tell us who you have there at the table with you.

Mr. TRACHTENBERG. Mr. Chairman, I am very pleased to reappear before this committee.

At my far right is Dennis Williams, who is the Budget Officer for the Department, and here to make sure we don't make any serious mistakes.

Next to him is Loran Archer, who is the Acting Director of the National Institute on Alcohol Abuse and Alcoholism.

And next to Mr. Archer is our newest appointee, Dr. Charles Robert Schuster, who is the new Director of the National Institute on Drug Abuse, just recently appointed.

To my immediate left is the agency's Budget Officer, Kent Augustson.

Next to Mr. Augustson is Dr. Shervert Frazier, the Director of the National Institute of Mental Health.

Next to Dr. Frazier is his Budget Officer, Ed Goody.

Next to Mr. Goody is Dr. Prescott, who is the Superintendent of St. Elizabeth's Hospital.

And next to Dr. Prescott is James Pittman, who is the Associate Director for St. Elizabeth's Hospital Transition Activities.

OPENING REMARKS

Mr. NATCHER. We are delighted to have all of you gentlemen before the committee, and at this time, Mr. Trachtenberg, we will be pleased to hear from you.

Mr. TRACHTENBERG. Thank you very much, Mr. Chairman. I would like to put my formal statement in the record, with your permission, and read a brief summary of that statement.

I am very pleased to be here as the Acting Administrator to discuss the President's fiscal year 1987 budget request for activities dealing with problems of alcoholism, drug abuse, and mental health.

These problems, Mr. Chairman, cost the nation an estimated $249 billion in 1983, including health care expenses, reduced productivity, accidents, and violence related to alcohol, drug, and mental health problems, as well as enormous personal suffering and family tragedies.

Fortunately, we are making steady progress toward prevention and treatment of these disorders. Some of the most important research findings in the entire health field today are being uncovered by scientists focusing on alcohol, drug abuse, and mental health issues.

For instance, in mental health research we are beginning to find the physiological basis of such widespread and chronic diseases as schizophrenia and Alzheimer's disease.

In drug abuse research we have the beginning development of the first effective treatment regimen for that insidious drug, cocaine.

In alcohol research, the importance of a genetic contribution to alcoholism has been firmly established. New recombinant DNA methods are now being employed to uncover the genetic mechanism involved.

The President's budget request of $892.2 million for fiscal year 1987 would allow our progress against ADM problems to continue. It maintains approximately the same level of funding as available in 1986, after the sequestration required by the Gramm-Rudman-Hollings Act.

The request for mental health research in fiscal year 1987 is $194.9 million. The NIMH would give special priority to areas such as schizophrenia, disorders of children and adolescents, mental health of the aging, and research in the basic sciences.

Regarding research on schizophrenia, for instance, scientific investigators will continue the search for causes of the illness, for potential predictors of treatment response and for ways to prevent relapse.

The variety of findings to date on schizophrenia has convinced researchers that this is not a single disease with a single cause. NIMH plans to launch a major effort to identify subtypes of the illness.

The Institute would also focus research on preventing impulsive behavior, such as suicide, which is a serious and growing problem among our teenagers.

The President's request for drug abuse research in fiscal year 1987 is $67.4 million, an increase of $2 million over the revised 1986 level. This would support slightly expanded research activity across the full spectrum of scientific work under way in NIDA programs to learn more about the many drug problems now harming our citizens, in particular our youngsters.

The 1985 high school survey showed a disturbing leveling off of the previous five-year downward trend in the use of several drugs. This is an adverse and possibly significant development which bears close watching and signals that we must not relax our efforts at prevention.

NIDA also will continue its vital research to find new treatment approaches for drug abuse. Today, very little is known about how to treat PCP and marijuana users. Developing treatment programs for these drugs, and for adolescents, would be priorities in 1987.

Under the President's request for the NIAAA, we are requesting $57 million. This would stress work to elucidate the genetics of alcoholism and expanded studies into the effects of alcohol on the cell, and the mechanisms by which alcohol produces intoxication, tolerance, and physical dependence.

NIAAA has also grown concerned over the great public health toll taken by alcohol-related trauma. There is a need to determine the influence of alcohol on severity of injury, the body's ability to recover, and interactions with medications commonly used in treatment of trauma.

Research also would be pursued on alcohol and pregnancy, new prevention approaches, and alcohol-related medical disorders.

Mr. Chairman, all three of our Institutes would continue and expand their research efforts related to AIDS. NIMH would study the psychobiological and psychosocial aspects of this devastating disease. NIDA would attempt to clarify the epidemiology and natural history of HTLV-III infection among intravenous drug users. NIAAA would study the effect of alcohol on the immune system's resistance to AIDS.

The President's 1987 budget request also includes $490 million for the ADMS block grant, $21 million over the amount available in 1986.

Mr. Chairman, thank you for the opportunity to present the President's FY '87 budget, and, with your permission, I would like Dr. Frazier to provide you a very brief overview of the St. Elizabeth's budget.

Mr. **Natcher**. Thank you. Mr. Trachtenberg. Dr. Frazier, we would be pleased to hear from you.

Dr. **Frazier**. Thank you, Mr. Chairman. I want to thank you for the opportunity to present the budget request for St. Elizabeth's Hospital. The request for fiscal year 1987 will be the last one submitted to you on behalf of the Hospital as an organizational part of NIMH.

Pursuant to the provisions of the St. Elizabeth's Hospital and District of Columbia Mental Health Services Act, the management responsibility for the services rendered by the St. Elizabeth's Hospital will be transferred to the District of Columbia on October 1, 1987.

The transfer legislation calls for certain preliminary steps, and these steps are either complete or well under way. First, Mayor Barry's Mental Health Systems Reorganization Office has completed a preliminary plan for implementing the District's mental health care system. This plan is now before the D.C. City Council for review.

The District has developed drafts of staffing patterns for each of their mental health service components, and these drafts are now being reviewed by all the interested parties.

Third, the Hospital's physical facilities have been audited and a report has been developed for the District's Mental Health Systems Reorganization Office. This information will be used for site planning and for the development of options for the best use of the physical plant.

Fourth, the Hospital's financial statements have been audited and have received unqualified approval as a fair representation of the Hospital's financial position. No material weaknesses were identified in the Hospital's internal fiscal controls.

And, finally, the Mayor has created a reorganization team charged with effecting a smooth transfer of control. The District, the Department, and the Hospital are represented on this team.

During the current year the Hospital will reduce its expenses by approximately $3.7 million, pursuant to the Budget Reduction and Deficit Control Act of 1985. We expect to achieve this target through hiring limitations, reductions in supplies, equipment, and contracts, and by enhancing revenues in areas not affected by sequestration.

This year, and under the 1987 budget, we expect to maintain the quality of patient care and complete all the final steps that are necessary for the transfer.

I will be pleased to answer any questions.

[The formal statements of Mr. Trachtenberg and Dr. Frazier follow:]

STATEMENT OF THE ADMINISTRATOR
ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

Mr. Chairman and Members of the Subcommittee:

I am pleased to appear before you as Acting Administrator of the Alcohol, Drug Abuse, and Mental Health Administration, to discuss the President's Fiscal Year 1987 budget request for activities dealing with these public health problems, which together cost the Nation an estimated $249 billion in 1983.

Mr. Chairman, even that exorbitant sum--which encompasses health care expenses, reduced productivity, costs of accidents and violence related to alcohol, drug, and mental health problems, and many other direct and indirect expenses--cannot take into account the personal suffering and individual tragedies attributable to these problems. Alcohol abuse contributes to a wide range of impairments and disease, including physical, mental, and emotional disorders. Alcohol is involved in 100,000 deaths annually in the U.S. and is strongly associated with traumatic injuries, the leading cause of death and disability for persons under 44. About one-third of the American household population has tried an illegal drug, and many thousands of persons -- young and old alike -- have drug abuse problems. A 1985 survey of high school seniors found that 17 percent-- the highest proportion ever--have used cocaine, the most powerfully addictive drug known. And recent surveys have shown that one out of every five of our citizens has a diagnosable mental health problem in any six-month period.

Fortunately, we are making steady progress toward prevention and treatment of these disorders through modern research programs that range from studies of etiology to development of treatment and prevention approaches. In fact, some of the most important research findings in the entire health field today are being uncovered by alcohol, drug abuse, and mental health scientists.

In mental health research, for instance, we are beginning to understand the chemical and molecular genetic function of the brain, and to find the physiological bases of such widespread and chronic diseases as schizophrenia and Alzheimer's disease. Significant progress has also been made in uncovering physiological factors in such functions as memory, cognitive processes, and sleep.

Drug abuse research also has realized many important advances, including the well-recognized breakthrough in identifying and elucidating opiate receptors and peptides in the brain. Another recent accomplishment is the beginning development of the first effective treatment regimen for cocaine users.

In alcohol research, the importance of the genetic contribution to alcoholism has been more firmly established, and new recombinant DNA methods are being employed to uncover the genetic mechanism involved. Other recent NIAAA research has made it increasingly clear that alcohol has adverse effects on the immune system.

Mr. Chairman, the President's budget for fiscal year 1987 would allow the Nation's march of progress against ADM problems to continue. The request seeks to maintain approximately the same current program level of funding as available in 1986, after the sequestration required by the Balanced Budget and Emergency Deficit Control Act of 1985.

The primary approach to maintaining this level of research activity would be establishment of 1,400 as the total number of investigator-initiated research project grants to be funded in 1987 and beyond. This total, along with maintaining the intramural research efforts of the three ADAMHA Institutes at their 1986 funding levels, would permit the agency to continue its most vital research within current fiscal restraints of the Federal budget.

The President's request for ADAMHA programs in 1987 is $802.2 million, including $318.9 million for research, $18.5 million for research training, $490 million for support of State services through the block grant program, and $7.4 million for program management. The total request represents an increase of $16.8 million over 1986, after sequestration of $42 million, and proposed rescissions of $40 million from the 1986 NIMH appropriation.

Proposed rescissions include $19 million for the NIMH clinical training program and $11 million for its community support programs. In part because of past Federal support for clinical training, a shortage of mental health professionals no longer exists. Community support demonstration grants have now been awarded in all States, and successful models can be replicated using block grant funds. Also included in the rescission is $10 million appropriated in fiscal year 1986 for a new mental health protection and advocacy program. The program would duplicate the States capacity to protect mentally ill persons from abuse and neglect.

Excluded from the President's request for ADAMHA is $13 million for AIDS research and technical assistance which are budgeted in the Office of the Assistant Secretary for Health to allow optimal coordination of all AIDS activities across the Public Health Service. Under this arrangement, ADAMHA would be reimbursed by PHS for research and other expenditures related to this crucially important disease.

Mr. Chairman, because development of new knowledge to reduce and prevent ADM problems is the pre-eminent purpose of our agency, I would like to devote the rest of my statement to describing briefly some research directions the ADAMHA Institutes would take in 1987 under the President's budget.

The request for mental health research in FY 1987 is $194.9 million. The Institute would assign special priority to areas such as schizophrenia, disorders of children and adolescents, mental health of the aging, and research in the basic sciences. The budget request increases the percentage of funds for each of these areas, selected on the basis of current scientific opportunities and the urgent need to expand knowledge related to them.

In research on schizophrenia, for instance, scientific investigators would continue the search for the causes of this illness and for potential predictors of treatment response and methods to prevent relapse. The heterogeneity of findings on schizophrenia has convinced researchers that this is not a single disease with a single cause. Based on that conclusion, NIMH in 1987 would launch a major effort to identify subtypes of the illness.

NIMH also would pay particular attention in FY 1987 to research on preventing impulsive behaviors such as suicide, which is a serious and growing problem among our teenagers. This effort would include studies of risk factors and of early diagnosis and treatment of depression in youth, known to be a key to many of these deaths.

In related activity, the Institute plans a major effort in 1987 to disseminate the considerable store of knowledge it has developed about the etiology, diagnosis, and treatment of depression. This effort--to be known as Project DART (Depression Awareness, Recognition, and Treatment)--is deemed necessary since, although depression is the most treatable of the major mental disorders, only one in five of its more than nine million victims currently seeks treatment. Furthermore, many general practitioners now lack the knowledge and skills they need to identify and treat patients who are suffering from this illness.

NIMH also would continue its current research activities aimed at understanding psychobiological and psychosocial aspects of AIDS.

The President's request for drug abuse research in FY 1987 is $67.4 million, an increase of $2 million over the revised 1986 level. This increase would support slightly expanded research activity across the full spectrum of scientific work underway in National Institute on Drug Abuse programs to learn more about many drug problems now harming our citizens, in particular our youngsters. The 1985 high school survey showed a leveling off of the previous 5-year downward trend in use of several drugs, an adverse development which bears close watching.

In 1987, drug abuse studies would include development of further understanding of how drugs act upon the brain, and of the precise cellular and central nervous system mechanisms involved. Additional research also would be conducted on the behavioral effects of drugs, and on the risks and consequences from drug abuse. For example, the number of people admitted to hospital emergency rooms following cocaine use increased 300 percent between 1980 and 1985. Increases of this magnitude are rare in public health areas, but quite common in the drug abuse field.

NIDA also would continue its vital research to find new treatment approaches for drug abuse. While much is known about how to treat narcotic users, and progress has recently been made toward developing treatment for cocaine abusers, very little is known about how to treat PCP and marijuana users. Developing treatment programs for these drugs, and for adolescents, would be priorities in 1987. The Institute also would direct its attention to the question of "cost effectiveness" of various treatment approaches, a point of ever greater concern as local treatment programs face increasingly stringent fiscal conditions.

A further priority would be on finding alternative data collection techniques to expand the range of information we gather on incidence and prevalence of drug abuse. There is constant fluctuation in the number of people using illicit drugs across the U.S., and in the ways they use them. While current information collection systems such as the National High School Survey represent dramatic improvements in data gathering since the drug abuse epidemic first hit our Nation, they are expensive and do not provide information on certain important groups in the population, such as high school dropouts, college students, and the homeless. NIDA would continue its search in 1987 for relatively inexpensive and rapid methods for obtaining improved information on drug trends.

NIDA research on AIDS would attempt to clarify the epidemiology and natural history of HTLV-III infection among intravenous drug users -- the second highest population at risk--and determine if drug use alters the course of the disease once it is contracted.

Another priority activity for NIDA in 1987, Mr. Chairman, will be to assist private organizations, companies, and schools in their efforts to combat drug abuse. The willingness of citizens at the grass roots to join the fight against drug abuse is one of the most encouraging developments of the 1980's, and we will do our utmost to continue to provide them technical support.

Under the President's request of $57 million for alcoholism research in FY 1987, the National Institute on Alcohol Abuse and Alcoholism would continue its scientific work to elucidate the genetics of alcoholism. It is increasingly evident that heredity is a major contributing cause of alcoholism and promising leads on genetic markers of this disease are beginning to emerge. Research in this area would include examination of genetic variations in the enzymes of alcohol metabolism, the structure and function of nerve cells, and electrophysiological traits.

The scheduled completion of the NIH centralized nuclear magnetic resonance (NMR) facility would allow an expansion of NIAAA's intramural studies into the effects of alcohol on the cell and the mechanisms by which alcohol produces intoxication, tolerance, and physical dependence. NMR technology also will be used to gain a better understanding of alcohol's effects on the structure and function of the brain and to develop methods for early identification of alcohol induced brain damage. Brain dysfunction is present in a high percentage of alcoholics, and organic brain syndrome associated with chronic alcohol abuse is second only to Alzheimer's disease as a cause of adult dementia.

The NIAAA also would place a major emphasis in 1987 on treatment research to address pressing questions on patient placement, such as the relative efficacy of different therapies ranging from detoxification to aftercare, appropriateness of inpatient versus outpatient treatment settings for different types of patients, and optimum length of stay in residential facilities.

Another NIAAA research emphasis in 1987 would be alcohol-related trauma, including studies to determine the influence of alcohol on severity of injury, the body's ability to recover, and interactions with medications commonly used in treatment of trauma. Research also would be pursued on alcohol and pregnancy, new prevention approaches, and alcohol-related medical disorders. The effects of alcohol on the immune system, particularly on resistance to AIDS, would receive special attention in 1987.

The President's 1987 budget request includes $490 million for Alcohol, Drug Abuse, and Mental Health Services block grants, $21 million over the amount available in 1986. The grants provide the States the flexibility to plan, implement, and control their own alcohol, drug abuse, and mental health services to best meet their communities' identified needs.

Statement of the Director

National Institute of Mental Health

on

Saint Elizabeths Hospital

Mr. Chairman and Members of the Committee:

Thank you for the opportunity to present the budget request for Saint Elizabeths Hospital. The request for Fiscal Year 1987 will be the last request submitted to you on behalf of the hospital as an organizational part of the Federal Government. Pursuant to the provisions of Public Law 98-621, The Saint Elizabeths Hospital and District of Columbia Mental Health Services Act, management responsibility for the services now rendered by Saint Elizabeths Hospital will be transferred to the District of Columbia government on the first day of Fiscal Year 1988. Our Fiscal Year 1987 budget is designed to continue delivery of quality mental health services during the remainder of Federal stewardship. In addition to delivery of quality care, preparation for transfer of management responsibility is our most important goal for Fiscal Year 1987. During FY 1986, much has been accomplished to support the transfer of responsibility while maintaining quality of care. I would like to briefly summarize our accomplishments in support of the goals of this major legislation:

- A Preliminary System Implementation Plan has been completed by the Mayor's Mental Health Systems Reorganization Office and has been submitted to the District of Columbia City Council for review.

  This plan describes a comprehensive approach to the delivery of community based public mental health services to all residents of the District of Columbia. It contemplates reasonable reductions in the chronic long term adult inpatient population of Saint Elizabeths Hospital and substantial increases in program support in the areas of adult ambulatory care, child and adolescent services and forensic psychiatric services. Over 150 Saint Elizabeths Hospital staff participated in the development of this comprehensive plan.

- Preliminary draft staffing patterns have been developed by the District of Columbia for each of the service components described in the Preliminary System Implementation Plan. These staffing patterns have been distributed to all interested parties within the system for analysis and review.

- Detailed analyses of the physical facilities located on the campus of Saint Elizabeths Hospital have been completed. These analyses include a full physical plant audit mandated by the Act and the report of a consultant to the Mental Health Systems Reorganization Office. The framework for site planning and development of alternative strategies for physical plant utilization have now been laid.

- An audit of the financial statements of Saint Elizabeths Hospital has been completed pursuant to the requirements of the Act. The results of the audit were the issuance of a unqualified opinion that the financial statements fairly represent the financial position of the Hospital and that no material weaknesses were identified in the internal control practices of the Hospital.

- The Mayor has created a Reorganization Implementation Team and charged it with the responsibility for finalizing transition plans and implementing the System Implementation Plan. This team, made up of high ranking officials of the District of Columbia Department of Human Services, Saint Elizabeths Hospital, and the Department of Health and Human Services has already begun the process of transition which will allow uninterrupted delivery of quality services during this important transition period.

The budget request submitted to you has been prepared on the assumption that programmatic activities will be maintained at current levels during FY 1987.

IMPACT OF GRAMM-RUDMAN LEGISLATION

However, consideration of the FY 1987 budget request necessarily requires analysis of the impact of the Budget Reduction and Deficit Control Act of 1985. Under this legislation, the Hospital will have approximately $3.7 million of its FY 1986 operating budget sequestered. As a result, the Hospital will achieve savings by imposing a hiring freeze for the remainder of the fiscal year which will bring its total staffing from approximately 3,385 persons to a target end of year workforce of 3,305. This represents a current-year reduction of 23 full-time equivalents, and will save approximately $1.3 million. In addition, reductions of approximately 3 percent in contract services, supplies, and equipment will save $1.3 million. Remaining reductions of $0.6 million in spending authority will be offset by increased reimbursements in areas not subject to Gramm Rudman sequestration. The FY 1987 budget request assumes maintenance of the current operating level. The Gramm Rudman legislation will not divert the Hospital from accomplishing its basic treatment mission for the remainder of FY 1986.

FISCAL YEAR 1987 GOALS AND OBJECTIVES

The Hospital's major focus during the remainder of FY 1986 and throughout FY 1987 will be preparation for a smooth transfer of treatment responsibilities to the District government consistent with the Preliminary System Implementation Plan. We do not intend to wait until October 1, 1987, to implement the major functional reorganization necessary to accomplish the District's new service delivery plan. During this period, we hope to accomplish the following objectives:

- Functional reorganization of Hospital inpatient programs to achieve alignment with the System Implementation Plan.
- Transfer of outpatient treatment responsibility from Hospital- based programs to existing community mental health centers, with appropriate reassignment of clinical staff to these centers.
- Completion of analysis of physical plant requirements to assure consistency with the District's physical plant utilization plan and redirection of unobligated facilities funds to final renovations.
- Completion of all necessary changes to the Preliminary System Implementation Plan consistent with the timetable contained in the legislation.
- Finalization of program staffing patterns preparatory to the transfer of employees to District government management on October 1, 1987.

BUDGET REQUEST

The total 1987 budget request for the Hospital assumes spending authority of $136,754,000, representing a net increase of $7,630,000 over FY 1986 after Gramm-Rudman sequestration. This amount includes $7,530,000 to maintain an operating level comparable to that of the original appropriation, and $100,000 to conduct an audit of accrued annual leave balances required by the transfer legislation.

The budget includes a Federal Appropriation of $36,353,000 and reimbursements totaling $100,401,000.00. The reimbursements include a projection of $76,798,000 in payments by the District of Columbia government, including the D.C. share of Medicaid reimbursements. The Hospital's projection of the District government payment represents a 22% increase over the FY 1986 level of $62,970,00.

Mr. Chairman, I will be pleased to answer any questions which you or members of the committee may have.

EFFECTS OF SEQUESTRATION

Mr. **Natcher**. Mr. Trachtenberg, Public Law 99-177, the Gramm-Rudman law, provides for the sequestration of almost $45 million for activities administered by the Alcohol, Drug Abuse and Mental Health Administration. Now, if you will, please, summarize just briefly for the committee what effect these cuts will have on these programs.

Mr. **Trachtenberg**. The required reduction is, as you know, Mr. Chairman, approximately 4.3 percent and we applied that percentage to each of the budget line items. In the research project grant area, sequestration will not cause a reduction in our continuation commitments. It will cause an approximate 18-percent overall reduction in new grants below what the appropriation level allowed. There will be a reduction in competing renewals only in NIAAA. The effect of these reductions will be to cut further below council recommended levels.

We will be reducing some projects in the other research mechanisms. We will be reducing approximately forty research trainees under the research training program. And there will be a cut of about $21 million in the block grant program, which is about 50 percent of the overall total cut due to sequestration.

Mr. **Natcher**. This sequestration, as you know, includes $3.7 million at St. Elizabeth's Hospital which your justification indicates may affect patient care. Explain first to the committee, if you will, how the sequestration amount for St. Elizabeth's was determined? How did you determine the amount?

Mr. **Trachtenberg**. I'd like Dr. Frazier to respond to that.

Mr. **Natcher**. All right, go right ahead, Dr. Frazier.

Dr. **Frazier**. I think it was 4.3 percent across the Board. It's pretty clear that we anticipated cutting costs of supplies and the amount of supplies, and also equipment, in delaying some of the repairs in equipment; also a more careful scheduling of patient care levels required, the intensity of the care, the number of personnel delivering the care on whatever shift the intensity of care required.

We expect to put a freeze on hiring. We expect also, if we have to save money, to do it in areas not involving patient care, but in administrative and other kinds of levels in the Hospital.

Mr. **Natcher**. Dr. Frazier, did this 4.3-percent also go to the unappropriated funds, or any other source of funds?

Mr. **Trachtenberg**. Mr. Goody?

Mr. **Goody**. Mr. Chairman, it affects both the appropriated and the reimbursement income. Of the $3.7 million, $1,879,000 is against the appropriation; $1,842,000 is levied against portions of reimbursements, and the types of reimbursements affected are specified by the definitions in Gramm-Rudman.

Mr. **Natcher**. Thank you. Will the Gramm-Rudman reductions affect the number of research projects or the number of research centers funded by the three institutions?

Mr. **Trachtenberg**. Gramm-Rudman in '86 will not, Mr. Chairman. In terms of the research projects, we will be operating under a new policy in 1987 which requires funding a total number of 1,400 research projects. This is the highest number ADAMHA has funded in the past seven or eight years.

So I would say in that respect research projects would not be affected.

And in '86 there will not be a cut in the number of research centers as a result of Gramm-Rudman.

Mr. **Natcher.** Will the sequestration order have any effect on staffing levels?

Mr. **Trachtenberg.** Actually we came out rather well on staffing levels, and there is no expectation of a furlough or a reduction-in-force.

RESEARCH PROJECT GRANTS

Mr. **Natcher.** We will insert in the record at this point a series of tables relating to the research programs which you prepare for the committee each year.

[Information follows:]

ADAMHA RESEARCH with AIDS
(dollars in thousands)

	NIMH	NIDA	NIAAA	Total
Total Research Budget				
1975	$92,578	$34,046	$10,967	$137,591
1976	93,804	33,760	11,717	139,281
1977	104,058	33,994	14,786	152,838
1978	111,189	33,986	16,165	161,340
1979	130,910	42,930	22,196	196,036
1980	143,515	45,972	22,229	211,716
1981	140,259	44,630	21,711	206,636
1982	143,787	41,026	23,337	208,150
1983	158,300	46,999	33,281	238,580
1984	174,967	55,540	42,866	273,373
1985	193,328	64,320	48,509	306,157
1986 Appropriation	214,000	74,000	57,000	345,000
1986 After Sequest.	204,798	70,817	54,550	330,165
1986 Revised Est.	204,798	70,817	54,550	330,165
1987 Estimate	199,925	73,210	56,618	329,753
Amount of New and Competing Grants				
1975	$19,250	$8,442	$4,504	$32,466
1976	18,259	7,123	2,143	27,525
1977	29,036	8,806	2,651	40,493
1978	23,324	9,010	3,735	36,069
1979	34,618	13,131	3,854	51,603
1980	31,510	11,784	3,882	47,176
1981	22,377	8,304	3,227	33,908
1982	27,948	8,863	3,664	40,475
1983	20,726	12,100	6,607	39,433
1984	30,621	15,222	9,502	55,345
1985	43,248	16,384	11,177	70,809
1986 Appropriation	43,365	18,157	12,156	73,678
1986 After Sequest.	38,190	16,384	11,105	65,679
1986 Revised Est.	38,190	16,384	11,105	65,679
1987 Estimate	35,928	15,931	7,421	59,280
Number or New and Competing Grants				
1975	339	120	74	533
1976	283	87	37	407
1977	377	124	37	538
1978	301	109	52	462
1979	401	149	51	601
1980	345	134	47	526
1981	228	79	29	336
1982	288	73	40	401
1983	203	97	65	365
1984	276	117	92	485
1985	319	131	100	550
1986 Appropriation	274	131	100	505
1986 After Sequest.	274	131	100	505
1986 Revised Est.	274	131	100	505
1987 Estimate	257	117	74	448

ADAMHA RESEARCH (excluding AIDS)
(dollars in thousands)

	NIMH	NIDA	NIAAA	Total
Total Research Budget				
1975	$92,578	$34,046	$10,967	$137,591
1976	93,804	33,760	11,717	139,281
1977	104,058	33,994	14,786	152,838
1978	111,189	33,986	16,165	161,340
1979	130,910	42,930	22,196	196,036
1980	143,515	45,972	22,229	211,716
1981	140,259	44,630	21,711	206,636
1982	143,787	41,026	23,337	208,150
1983	158,098	46,685	33,281	238,064
1984	173,762	55,954	42,866	270,582
1985	191,526	63,760	48,509	303,795
1986 Appropriation	210,297	68,683	57,000	335,980
1986 After Sequest.	201,095	65,500	54,550	321,145
1986 Revised Est.	201,095	65,500	54,550	321,145
1987 Estimate	194,890	67,405	56,618	318,913
Amount of New and Competing Grants				
1975	$19,250	$8,442	$4,504	$32,466
1976	18,259	7,123	2,143	27,525
1977	29,036	8,806	2,651	40,493
1978	23,324	9,010	3,735	36,069
1979	34,618	13,131	3,854	51,603
1980	31,510	11,784	3,882	47,176
1981	22,377	8,304	3,227	33,908
1982	27,948	8,863	3,664	40,475
1983	20,514	11,832	6,607	38,953
1984	29,789	14,711	9,502	54,002
1985	42,455	16,384	11,177	70,016
1986 Appropriation	42,508	16,988	12,156	71,652
1986 After Sequest.	37,370	15,265	11,105	63,740
1986 Revised Est.	37,370	15,265	11,105	63,740
1987 Estimate	35,928	15,931	7,421	59,280
Number or New and Competing Grants				
1975	339	120	74	533
1976	283	87	37	407
1977	377	124	37	538
1978	301	109	52	462
1979	401	149	51	601
1980	345	134	47	526
1981	228	79	29	336
1982	288	73	40	401
1983	200	96	65	361
1984	268	113	92	473
1985	312	131	100	543
1986 Appropriation	267	129	100	496
1986 After Sequest.	267	129	100	496
1986 Revised Est.	267	129	100	496
1987 Estimate	257	117	74	448

	NIMH	NIDA	NIAAA	Total
Percent Funded of Number of Approved Applications				
1975	52%	65%	73%	57%
1976	55%	59%	66%	57%
1977	49%	61%	33%	50%
1978	41%	57%	45%	45%
1979	59%	60%	48%	58%
1980	54%	56%	33%	51%
1981	36%	35%	23%	34%
1982	50%	30%	36%	43%
1983	41%	42%	31%	39%
1984	43%	47%	33%	42%
1985	42%	55%	33%	43%
1986 After Sequest.	32%	40%	32%	34%
1986 Revised Est.	32%	40%	32%	34%
1987 Estimate	29%	36%	24%	29%
Percent Funded of Dollar Amount of Approved Applications				
1978	47%	63%	50%	51%
1979	62%	66%	52%	62%
1980	60%	60%	36%	57%
1981	40%	36%	28%	37%
1982	45%	32%	30%	39%
1983	41%	41%	32%	40%
1984	40%	46%	27%	38%
1985	42%	55%	32%	45%
90% Payline of Funded Projects				
1975	244	283	377	280
1976	269	278	340	281
1977	267	256	293	265
1978	259	229	262	254
1979	260	244	221	250
1980	267	236	210	257
1981	220	208	219	219
1982	214	175	198	206
1983	170	170	189	180
1984	170	167	178	172
1985	162	172	183	168
1986 After Sequest.	147	154	172	153
1986 Revised Est.	147	154	172	153
1987 Estimate	145	150	158	148

Mental Health Research by Program Area
Payline for Budget Categories
FY 1984 to 1987 Estimate

	1984 Actual	1985 A/ Actual	1986 Approp.	1986 Sequest.	1986 B/ Revised	1987 C/ Estimate
Basic Studies						
Neurological/ Behavioral Sci.	167	159	154	146	146	144
Schizophrenia Disorders......	160	152	164	156	156	154
Depression & Manic Depessive	170	162	143	136	136	134
Mental Disorders of Aging......	180	172	152	144	144	142
Childhood & Adol. Disorders	170	162	163	155	155	153
Anxiety Disorders	170	162	143	136	136	134
Behavioral Med./ Stress Related Disorders.....	190	181	154	146	144	142
Epidemiology/ Biometry......	195	186	149	141	141	139
Prevention.....	187	178	135	128	128	126
Other MH Prob..	184	175	146	138	138	136
Total.......	170	162	155	147	147	145

Percent Funded of all Eligible

	1985 Actual A/	1986 Approp.	1986 Sequest.	1986 B/ Revised	1987 C/ Estimate
Basic Studies					
Neurological/ Behavioral Sci.	32%	32%	24%	24%	22%
Schizophrenic Disorders......	44%	44%	34%	34%	31%
Depression & Manic Depressive	44%	44%	34%	34%	31%
Mental Disorders of Aging......	52%	52%	40%	40%	36%
Childhood & Adolescent Disorders.....	42%	42%	32%	32%	29%

Anxiety Disorders	45%	45%	34%	34%	31%
Behavioral Med./ Stress Related Disorders......	49%	49%	37%	37%	34%
Epidemiology/ Biometry.......	66%	66%	50%	50%	45%
Prevention......	64%	64%	49%	49%	44%
Other MH Prob...	29%	29%	22%	22%	20%
Total.........	42%	42%	32%	32%	29%

A/ No change in 1985 data, with or without AIDS.

B/ FY 1986 Revised column excludes AIDS. There are no other differences between this and the sequestered column.

C/ No change to 1987 if AIDS were restored. All AIDS grants in 1987 are continuations.

Mr. **Natcher**. These charts show a smaller number of new grants in 1986 than had been expected when the appropriations were passed last fall. If you will, now, tell the committee why the number of new grants has been reduced from 550 to 505.

Mr. **Trachtenberg**. Well, Mr. Chairman, I'd like to divide that answer out into two parts, if I may. The first part applies to eliminating ten of those grants, lowering it from 550 to 540. That action reflects a compromise between Congressional staff and OMB in that the additional ten grants were considered a one-time increase. So we were starting with a base of 540.

Now, the next question is: How do we get from 540 down to 505, or a difference of 35 grants? What occurred is that as we developed our '85 budget, we were on target in terms of the continuation dollars, but not in the number of continuations that we estimated would go into '86 and the outyears. As we got further into the development of the budget we realized our estimates were off. There is always some difference, but it has not been a great problem to adjust the number of continuations because we have been building our budgets on the basis of new and competing grants.

Well, in this particular year, as you know, we began working from a total-grant basis of 1,408 in '86 and 1,400 in '87. When you are dealing with a total number of grants, then you realize that, if you must increase continuations by 35, which is what we had to do because we had a commitment in those, then you will have 35 less in new and competing given a limited total.

That 35 reduced us to the 505 level for new and competing grants.

The net dollars are the same, but the number of new and competing will indeed be less in '86.

STABILIZATION OF RESEARCH GRANTS

Mr. **Natcher**. The 1987 budget proposes to fund 1,400 total grants.

Why are you describing your research funding policy in terms of total numbers of grants rather than the number of new grants such as in previous years—new grants used in previous years?

Mr. **Trachtenberg**. Well, you correctly note a departure from existing policy. It's a new policy that was established in the President's budget, applicable both to us and to NIH.

And it's difficult to say there is stabilization when you just use new and competing grants as your base, because the total number constantly changes, based upon the length of the grant. Some grants could be three years, some grants could be five years, some grants could even be seven years. So there was no real stabilization of the total number. By having a total number, 1,400, there are some negatives, in our view. On the other hand, it does give us a total package to deal with, not just a commitment to fund new and competing grants but the ability to adjust the length of the various grants to suit the particular programs that we are supporting.

So it's a new approach, and I think, in our view, the jury is out in terms of how effective it will be. But I think it is certainly worth a try.

Mr. **Natcher**. As you know, the President's budget proposes bill language which would legislate a minimum number of grants for both NIH and ADAMHA. In previous years, as you know, you have opposed specifying numbers of grants in the bill.

Why have you changed your mind in 1987?

Mr. **Trachtenberg**. Well, these decisions get made at higher levels but I would assume that the reason is because of the change in policy to fund a total number of grants. Once you go to a total number of grants, you have then a floor, and it's a bit more controllable—so I think probably whoever made that decision felt more comfortable adopting this policy then in legislating the number.

I note that it says "not less than 19,400," and that makes me feel a little bit more comfortable, frankly.

Mr. **Natcher**. If the 1986 bill had specified the total number of grants for Alcohol, Drug Abuse and Mental Health, how would you have dealt with the shortfall for continuation costs which in fact developed? How would you have done that?

Mr. **Trachtenberg**. The way we are currently doing it, Mr. Chairman. We would fund fewer new and competing grants and meeting our commitments to current grantees.

Mr. **Natcher**. All right, Mr. Stokes, I yield to you.

COMMUNITY SUPPORT PROGRAM

Mr. **Stokes**. Thank you, Mr. Chairman. Mr. Trachtenberg, just three months ago, the President signed the Fiscal Year 1986 Labor, Health, Human Services, and Education Appropriations Act. That bill includes funding for the Community Support Program and for the Clinical Training Program. Now you are proposing to rescind the funds provided for these programs.

According to the Children's Defense Fund, one of three of the most disturbed children do not receive the services that they need. The child and adolescent service system program is part of the Community Support Program. This program helps states, such as Ohio, in developing mechanisms to provide a continuum of services for emotionally disturbed children.

What evidence do you have to suggest that the need for this type of program no longer exists?

Mr. **Trachtenberg**. I wouldn't suggest by the proposal, Mr. Stokes, that we are saying that the need doesn't exist. I think the question is one of priorities, where the responsibility should lie between the Federal government and the States.

I think that the Congress recognized in one of the amendments to the block grant legislation that there should be a clear focusing by the States on how to deal with these severe disorders of children. And I think there are block grant dollars that can be applied to this program. I don't want to come off hard-hearted and say that these children don't need that money, but I think that the funding has to come from a different source.

DRUG ABUSE PREVENTION AND TREATMENT PROGRAMS

Mr. **Stokes**. Your budget justification refers to the fact that the growing number of people seeking treatment for drug abuse is placing an increasingly heavy burden on the national treatment system. Yesterday, in *The Washington Post*, there was an article reporting on increased use of cocaine and heroin, increased deaths from overdoses and simultaneous use of dangerous drugs and their usage by middle-class Americans.

Do you believe that we are doing all that we can to promote drug abuse prevention and treatment programs?

Mr. TRACHTENBERG. I'm going to let the new kid on the block, Dr. Schuster, answer that one, if it's all right with you, Mr. Stokes.

Mr. STOKES. Dr. Schuster?

Dr. SCHUSTER. Well, I share your concern about the increasing incidence of the abuse of cocaine and heroin. The statistics are alarming.

In terms of treatment, particularly in the area of cocaine abuse, we have had some major accomplishments in the past year. There are pharmacological interventions that are now being shown to be useful in the treatment of cocaine dependence, as well as certain forms of behavioral therapy and psychotherapy which are being used.

There is no question that we need more research to develop better techniques for the treatment of cocaine abuse although we have made significant progress in this area. In the past year we have had one major workshop and seminar in which we described treatment techniques for cocaine.

In the area of prevention, I viewed yesterday eight video presentations that are going to be introduced to the American public tomorrow. They are extremely powerful, and the bottom-line message of them is very simple: Anybody that tells you that cocaine is not addicting, lies.

I found these video tapes very powerful—and I have been in this business for a long time. By the time I finished watching them, I was ready to weep. These are not actors; these are eight human beings who had a serious cocaine problem and who are now in treatment.

I believe this kind of presentation is going to go a long way in debunking the myth that cocaine is a safe drug.

As far as heroin and the problem of heroin addiction are concerned, we have also made some important breakthroughs. As you know, methadone maintenance has been one of the major treatments in the United States for heroin dependence. In addition, there is a new form of treatment called Naltrexone, which is a narcotic antagonist—it blocks the high that heroin users get from it.

One of the major problems with Naltrexone is that it is difficult to get a patient who wants to get high on heroin to take a drug which has no other effect than to block the high. And NIDA-sponsored research in the past year has developed techniques for having a depot injection of Naltrexone that will block the ability to get high on heroin for several weeks, and perhaps even longer. Now the compliance issue is going to be eased because of that.

We are making progress in this area, but, clearly, a great deal more needs to be done.

ADMS BLOCK GRANT

Mr. **Stokes**. I appreciate that. The funding for the Alcohol, Drug Abuse and Mental Health Block Grant would be cut by $21 million under the 1986 Gramm-Rudman reductions.

Is this an area for which we should consider a supplemental appropriation in order to restore this reduction?

Mr. **Trachtenberg**. The way the budget was built--as you know, Mr. Stokes, required that each of the line items take the same 4.3 percent reduction. While it is going to be a sizeable reduction, when spread over the States, I think the individual reductions are manageable. The important thing to note is that in FY '87 the money gets restored back to the $490-million level, and so it's only a temporary reduction in funding.

Mr. **Stokes**. What portion of the block grant funds are being utilized for drug abuse prevention and treatment services? Do you have that figure?

Mr. **Trachtenberg**. Generally, the alcohol and drug abuse funding runs about half the block grant, and mental health services represents the other half of the block grant. But we could provide more specific data for the record.

Mr. **Stokes**. I'd appreciate that. Thank you, Mr. Chairman.

[The information follows:]

Drug Abuse Services Within the Block Grant

In total, 49.24% of the block grant funds are allocated to mental health activities and 50.76% to substance abuse activities (alcohol and drug abuse). Of the funds available for substance abuse, at least 35% must be used for programs and activities relating to drug abuse while 20% must be used for prevention and early intervention programs designed to discourage the abuse of alcohol or drugs or both.

Mr. **Natcher**. Mr. Hoyer?

ECONOMIC COSTS TO SOCIETY

Mr. **Hoyer**. Thank you, Mr. Chairman. Mr. Trachtenberg, I'd like to ask you a general question.

In your statement, you indicate "which together cost the nation an estimated $249 billion in 1983." Do you have the ability to break that figure down for me as it relates to alcohol versus drugs? And also I suppose there is a mental health component of that as well.

Mr. **Trachtenberg**. The problem is that many of the indirect costs tied to the mental health area are not definable as in the alcohol and drug areas. But basically that $249 billion breaks down to $116.7 billion for alcohol abuse, $59.7 for drug abuse, and $72.8 billion for mental illness.

Mr. **Hoyer**. Are you aware of the President's Crime Commission report?

Mr. **Trachtenberg**. Only to the extent that I read about it in the newspaper, Mr. Hoyer.

TESTING OF FEDERAL EMPLOYEES FOR DRUG ABUSE

Mr. **Hoyer**. I don't know whether you've talked to anybody about my views on this, but there is no doubt in my mind that alcohol is the single most abused drug in this country. It breaks up more families, destroys more individuals, causes more pain and suffering, in my opinion, than any other abused substance in this nation.

The Attorney General, of course, is not recommending that we require a breath-o-lyzer test of every Federal employee that comes to work in the morning, notwithstanding the fact that your figures indicate that alcohol is twice the problem that drugs are. Now, drugs are a serious problem—Substance abuse is a serious problem across the board.

But I am very pleased to hear my own view corroborated—I guess I am not pleased to hear that it's corroborated in any extent that we have the magnitude of the problem that we clearly do. We ought to address it.

Can you give me a ballpark guess of how much it would cost to test two million Federal employees for drug abuse, presumably one or more periodic urinalyses twice a month?

Mr. **Trachtenberg**. I wouldn't even hazard a guess, but, if you would like, I could try to compute something for the record. We have done a lot of work, as you know, in terms of developing the techniques in the area of—

Mr. **Hoyer**. Can you give me a figure? How much does it cost for a single urinalysis for substance abuse?

Dr. **Schuster**. If I may answer, this really depends to a great extent on how many substances you are looking for. There are routine screens that look for four or five commonly abused drugs that are probably in the ballpark of $20.

Mr. **Hoyer**. $20 per test?

Dr. **Schuster**. Yes. However, you go on from there, and if you are going to be using this for forensic or legal purposes, it is oftentimes necessary to back up those tests with much more sophisticated tests, in the case of positive findings, and so the cost escalates in there, and I wouldn't want to——

Mr. **Hoyer**. I'm aware of that, but what you are telling me is that if we wanted to test two million Federal employees for the use of drugs one time, it would cost us $40 million; presumably if we wanted to do that more than once per year, it would escalate by whatever factor the number of tests would be.

Let me ask Dr. Frazier, I am obviously not looking to you for specific information other than ballpark figures.

FTE REDUCTIONS

Dr. Frazier, is your Institute going to have to furlough or RIF employees in 1986 or 1987?

Dr. **Frazier**. We don't have any plan to, Mr. Hoyer.

PROPOSED 1986 RESCISSIONS

Mr. **Hoyer**. OK, what programs are adversely affected by the '86 rescission?

Dr. **Frazier**. The '86 rescission?

Mr. **Hoyer**. Gramm-Rudman.

Dr. **Frazier**. That is the——

Mr. **Hoyer**. Excuse me, the Gramm-Rudman cut and/or the rescission.

Dr. FRAZIER. Well, the Gramm-Rudman is 4.3 percent across the board for every program.

Mr. HOYER. What rescissions do you have?

Dr. FRAZIER. The rescissions are the community support program, the clinical training program. And the protection and advocacy appropriation.

Mr. HOYER. Was that your recommendation?

Dr. FRAZIER. That's part of the budget which we helped develop, yes.

Mr. HOYER. I am not sure I understood that answer. I understand it's part of the budget, and I understand the budget comes from OMB. My question to you was: Was that your recommendation to OMB?

Dr. FRAZIER. I don't remember that I made such a recommendation.

Mr. TRACHTENBERG. It was my recommendation, Mr. Hoyer. I, for a number of years now, have advocated, particularly with respect to clinical training, that the NIMH has done an outstanding job of developing the infrastructure of the four core mental health disciplines in this country. With this completed, we are now at a point where, in my view, finding of that program was interfering with support for the higher priority programs of the agency, particularly its research and research-training missions during this time of limited resources.

Mr. HOYER. Let me skip to another subject. I've got a number of questions here, and our time is limited.

PUBLIC PSYCHIATRIC INITIATIVE

What are the results to date of your public psychiatric initiative? My understanding is that that was modelled on Maryland's initiative. Can you tell me the results?

Dr. FRAZIER. We have had a public psychiatric initiative in a number of States, and it's been successful. With support from our State Manpower Development and Community Support programs, the States have had good results in developing ways to improve services for the chronically mentally ill. The Maryland program is our star program in the sense that it has all the necessary ingredients and is also well coordinated, has a university affiliation, and also is successful.

Mr. HOYER. Thank you, again. I'd like to go further into that, but our time is very limited.

MINORITY RESEARCH TRAINING

What is the impact of the NIMH reorganization of minority research training?

Dr. FRAZIER. The reorganization has brought all the minority research training into one branch in one of the divisions, under the leadership of one person. That means that we can carefully monitor our commitment to ongoing research efforts, research training, and research issues for minority persons in minority subjects.

In addition, we have an associate director for special populations whose responsibility is to see that every single division and every office in the Institute pays attention to minority issues and our dedication to minority problems.

Mr. **Hoyer**. Would it be fair to conclude from that answer, Doctor, that there is no diminution in resources dedicated to that objective?

Dr. **Frazier**. There is no diminution except for clinical training which is proposed for rescission this year. Otherwise, there is a 2- or 4-percent increase in resources for minority issues within the Institute.

MINORITY HEALTH PROBLEMS

Mr. **Hoyer**. One last question during this round. In the black and minority health task force report which we discussed yesterday to some degree, the category of homicide and accidents has been identified as one of the six major health problems in minority populations.

Has NIMH made any specific plans to deal with this problem? Is it dealing with this problem?

Dr. **Frazier**. The black homicide issue is one of the 1990 objectives, and our branch in anti-social and violent behavior is looking at the problem of black homicide. We have conducted research in the past on homicide and other forms of violence. We are actively involved in minority-black issues relevant to homicide.

Mr. **Hoyer**. At the same level of resources increased from last year?

Dr. **Frazier**. Exactly.

Mr. **Hoyer**. Would the 2 to 4 percent apply to that as well?

Dr. **Frazier**. Yes.

Mr. **Hoyer**. Thank you, Mr. Chairman. I have some more questions. I will ask them on the next round.

RESEARCH GRANTS

Mr. **Natcher**. The data on research shows a reduction in the number of new grants from 550 in 1985 to 505 in 1986, and 448, as you know, in 1987. These tables also show that this would result in an ability to fund only 29 percent of the approved applications and that the payline would fall below 150.

Now, Mr. Trachtenberg, what in your opinion is the justification of a more-than-20-percent reduction over two years? How do you justify it?

Mr. **Trachtenberg**. Well, that is one of the aspects of going to a total-grant concept, Mr. Chairman. In effect, what's happening is that we have a certain number of continuation grants that we must fund. And when you spend your money on meeting those commitments it reduces the amount of new and competing that you have available.

The 29 percent is slightly lower than what we might prefer, but a good deal of excellent research will be done, and in a time of fiscal austerity, we are prepared to live with that.

RESTORATION OF NIMH GRANTS TO THE 1985 LEVEL

Mr. NATCHER. Dr. Frazier, in 1985 the National Institute of Mental Health was able to fund 319 projects at a payline of 162. The 1987 budget would support 257 projects with a score of 145.

Tell us, if you will, please, how much money would have to be added to your budget to restore the program to the 1985 level, and if you will also tell us what that money might buy generally?

Dr. FRAZIER. In order to restore the number of grants to the level of 319 for new and competing in the budget, the estimate is $9.17 million. That is at the average cost which we are now finding in order to make that happen. An additional $85 million would be necessary to fully fund all grants at council recommended levels.

Mr. NATCHER. What would it buy us?

Dr. FRAZIER. We would be able to award grants at council approved levels. We would step up our efforts to build the research base in schizophrenia, basic brain studies, mental disorders of children, and problems of aging. We have adequate numbers of good applications, highly prioritized, said to be top-level by the peer-review process.

To state it another way, it would buy us an increased workforce working on difficult problems. It would buy us quicker solutions to the answers which we need. It would give us an increased opportunity to train some new young researchers who have new ideas about the major illnesses which we face.

RESTORATION OF NIDA GRANTS TO THE 1985 LEVEL

Mr. NATCHER. Dr. Schuster, let me put the same question to you regarding drug abuse. In 1985, your Institute, as you know, funded 131 new projects with a score of 172 or better. The 1987 budget would support 117 at a score of 150.

How much would it cost to go back to the 1985 level of effort and what would we buy with this additional investment?

What do we have here, Dr. Schuster?

Dr. SCHUSTER. Well, there's a difference of 14 grants between those two figures. And I will provide an exact figure for the record, but the average cost of our new and competing grants, after the necessary reductions which we have made in the past years, is around $157,000. So I would have to multiply it out in order to get a proper figure.

[The information follows:]

In order to restore the number of new and completing grants to the 1985 level, the NIDA would require an additional $2.2 million. Additional funds necessary to fully fund all grants would be $4.3 million for a total of $6.5 million.

Dr. SCHUSTER. However, at the same time, we have been reducing the payment of grants, the average size of grants, over the past few years, as Mr. Trachtenberg said. Having just come from a university, I know that this kind of shortfall does have major effects on researchers.

It is not only the number of new grants, but also the percentage reduction which established grants have taken. And I would point out that the major effect that I fear about this is that when you have to sacrifice certain projects because of the fact that your grant has been reduced by X percent, you tend to do the safer research. Researchers have a product, which are publications, and what I fear is, with this kind of reduction, it is possible that we will not see the innovative, riskier research done under these circumstances.

So I think this is a problem.

On the other hand, some of the reductions that I have seen have improved the efficiency of university researchers; they get by with a little less before it really begins to have an impact.

RESTORATION OF NIAAA GRANTS TO THE 1985 LEVELS

Mr. NATCHER. Now, Mr. Archer, what about the Alcohol Institute? In 1985 100 projects were funded; the 1987 budget would fund only 74 new grants.

What can you tell us about the cost of restoring the budget to the 1985 level and how these additional funds might be used? What about it, Mr. Archer?

Mr. ARCHER. Mr. Chairman, the dollar amount for the restoration of the 26 grants to bring us back to 100 would be $2.8 million. Additional funds necessary to fully fund all grants at Council recommended levels would be an additional $2.3 million—a total of $5 million.

The areas in which we have found significant research opportunities and breakthroughs have been in the areas of genetics as a way of developing more effective prevention, as well as research which we anticipate in the area of improved treatment research. Those would be the two primary areas that we would be stressing—prevention and treatment research.

RESEARCH CENTERS

Mr. NATCHER. Thank you, Mr. Archer. Mr. Trachtenberg, let's turn to your research centers program. Your justifications show 35 center in '86 that we plan to open at the University of Maryland,

Which new center will be funded this year and which centers do you intend to close in 1987?

Mr. TRACHTENBERG. I believe we have one new schizophrenia center in '86 that we plan to open at the University of Maryland, and two AIDS centers.

Those are the three new centers for 1986, Mr. Chairman.

Mr. NATCHER. What about the ones that you are closing in 1987? Where are they located?

Mr. TRACHTENBERG. The budget indicates there will be a shortfall in the number of competing centers, one in NIDA and four in NIMH.

At this point, we plain to do everything possible to avoid closing any of those centers. This assumes that the centers will receive good competitive scores and that their research will continue to be relevant to the purposes of our programs.

We may also have to reduce some of the other centers in size to make up for the shortfall. There are a number of options available to us.

Mr. NATCHER. Has it been agreed upon up to this time that certain centers will be closed?

Mr. **Trachtenberg.** No.

Mr. **Natcher.** It has not. Do you think it may mean that we may have to reduce a number of the centers, according to the justifications, maybe from 36 to 31?

Mr. **Trachtenberg.** That's right; those are the four in NIMH and the one in NIDA.

Mr. **Natcher.** We'll insert in the record at this point a table showing the funding level for the various research mechanisms over the last several years. This table shows a steady increase for individual grants and for centers, but a deterioration in support for "other mechanisms."

[Information follows:]

ADAMHA Research by Mechanism
(dollars in thousands)

	1984	1985	1986	1986 Revised	1987
Extramural:					
Research Centers	$21,508	$22,162	$23,385	$22,593	$19,707
Contracts	13,691	11,511	11,108	9,694	9,001
All Other	22,862	23,068	24,213	22,605	17,303
Subtotal, Other	58,061	56,741	58,706	54,892	46,011
Project Grants	148,913	177,448	204,434	195,478	199,090
Subtotal, Extram	206,974	234,189	263,140	250,370	245,101
Intramural:	64,265	71,740	72,840	69,683	73,812
Total	$271,239	$305,929	$335,980	$320,053	$318,913

Mechanism Percentages

	1984	1985	1986	1986 Revised	1987
Extramural:					
Research Centers	7.9%	7.2%	7.0%	7.1%	6.2%
Contracts	5.0%	3.8%	3.3%	3.0%	2.8%
All Other	8.4%	7.5%	7.2%	7.1%	5.4%
Subtotal, Other	21.4%	18.5%	17.5%	17.2%	14.4%
Project Grants	54.9%	58.0%	60.8%	61.1%	62.4%
Subtotal, Extram	76.3%	76.6%	78.3%	78.2%	76.9%
Intramural:	23.7%	23.4%	21.7%	21.8%	23.1%
Total	100.0%	100.0%	100.0%	100.0%	100.0%

NOTE: All columns exclude AIDS for comparablility purposes.

FUNDING FOR OTHER RESEARCH MECHANISMS

Many of our public witnesses last year, Mr. Trachtenberg, testified that the concentration on numbers of grants and centers had resulted in an erosion of other critical resources.

As Congress reviews these priorities, what advice would you offer on the need for funding for "other mechanisms"?

Mr. **Trachtenberg**. Well, let me make just a couple of points, Mr. Chairman.

First of all, you know, we are happy for little things, and one of the little things is the fact that overall our research budget between '86 and '87 is basically stable, so we are very pleased with that outcome.

In terms of the other research mechanisms, the witnesses have correctly testified that as we try to build and sustain a stabilized level of new and competing project grants, as we try to maintain a stabilized intramural research program which is central to our agency there are few dollars left for other research mechanisms. And, indeed, that is where we budget for research centers, and for developmental activities such as small grants and research development awards. Those activities have been hurt in the past because they have been funded from the limited resources remaining.

RESEARCH GRANT SHORTFALL

Mr. **Natcher**. These witnesses also described a problem with funding for individual grants being reduced arbitrarily in order to maintain the number of awards. This was described as the so-called "shortfall issue."

What has been the average reduction at each of the institutes over each of the last 3 years?

Mr. **Trachtenberg**. I have '86 and '87, if you are interested in that, Mr. Chairman.

Mr. **Natcher**. Go right ahead.

Mr. **Trachtenberg**. The following reductions are below the amounts recommended by our advisory councils. NIMH continuations in '86 are going to be reduced 3 percent, in '87 5 percent; new and competing in '86 will be reduced 8 percent, in '87 12 percent. NIDA will have a more significant shortfall. Continuations in '86 will be reduced by 9 percent, '87 5 percent. New and competing in '86 will be reduced 17 percent below Council-recommended levels, and in '87 13 percent below Council-recommended levels. In NIAAA, continuations in '86 will be reduced 2 percent, in '87 3 percent. New and competing grants will be reduced 9 percent in '86, and 16 percent in '87.

Overall, Mr. Chairman, there will be 4 percent reduction for continuations in '86, in '87, a 6 percent reduction. For new and competing grants there will be 12 percent reduction '86, and a 14 percent reduction in '87.

Mr. **Natcher**. Thank you very much. Mr. Trachtenberg, tell us what amount of money it would take to restore the shortfall issue here. You can place that in the record, if you don't have it.

Mr. **Trachtenberg**. To pay at Council-recommended approval for all out——

Mr. **Natcher**. Right.

Mr. **Trachtenberg**. I would like to submit that for the record, if I could, Mr. Chairman.

[The Information follows:]

ADAMHA SHORTFALL IN REGULAR RESEARCH AWARDS

[Dollars in thousands]

	1986 Shortfall [1]		1987 Shortfall [2]	
	Amount	Percent	Amount	Percent
NIMH:				
Continuations	$2,019	2.6	$3,673	4.5
New/Competing	3,292	7.9	4,799	11.8
Total	5,311	4.4	8,472	7.2
NIDA:				
Continuations	3,188	8.6	1,947	5.1
New/Competing	3,382	17.1	2,388	13.0
Total	6,570	11.5	4,335	7.6
NIAAA:				
Continuations	434	1.9	830	3.1
New/Competing	1,129	9.2	1,433	16.2
Total	1,563	4.5	2,263	6.3
Agency:				
Continuations	5,641	4.1	6,450	4.4
New/Competing	7,803	10.6	8,620	12.7
Total	13,444	6.3	15,070	6.9

[1] Total number of grants budgeted is 1,408.
[2] Total number of grants budgeted is 1,400.

QUALITY OF RESEARCH

Mr. **Natcher**. That will be fine. What effect, in your opinion, has this squeezing of grants had on the quality of the research generally that we are funding?

Mr. **Trachtenberg**. I don't think it's hurt the quality of research. I think the issue is to what extent it has slowed down the pace of advancement in these fields. We are funding less research, but not poorer quality research.

Mr. **Natcher**. Mr. Conte, I yield to you.

RESEARCH GRANTS

Mr. **Conte**. Thank you, Mr. Chairman. Mr. Trachtenberg, earlier you indicated that you consider your grant base for 1985 and 1986 as 540 instead of 550 because of an agreement between OMB and Congressional staff that ten grants would be one-year only.

Tell me about that agreement, and what Congressional staff were involved? I happen to be the guy that brought it up to 550.

Mr. **Trachtenberg**. Mr. Conte, where I sit in the organization level, I just get my marching orders. I was not a party to that negotiation.

Mr. **Conte**. I don't care who's marching, I want to know who you are marching with. What staff?

Mr. **Trachtenberg**. My understanding was that it came from OMB staff and Congressional staff, and that the 550 agreement was for one-year only and that the next year it was going to be 540.

Mr. **Conte**. Sounds like OMB was marching alone trying to circumvent the agreement we made.

Mr. **Trachtenberg**. I can't comment on that, Mr. Conte.

Mr. **Conte**. So you don't know of any Congressional staff with whom an agreement supposedly was made?

Mr. **Trachtenberg**. Personally know of them? No.

RESTORATION TO PRE-SEQUESTRATION LEVELS

Mr. **Conte**. If in the FY '87 appropriation bill we are going to try to restore some accounts to their pre-sequestration level of service, I believe ADAMHA is one of the first, and we should try to take care of it at least on an equal basis with NIH.

What would it take in terms of funding to restore ADAMHA to the pre-sequestration level of service, assuming the number of new and competing grants in FY '87 as they are in FY '86 were enacted?

Mr. **Trachtenberg**. Well, if I counted up what everyone said would be needed to move from 448 grants back to the 550 level, or an increase of 102 grants, we are talking about $14.1 million, Mr. Conte.

Mr. **Conte**. Could you break that down by Institutes for the record?

Mr. **Trachtenberg**. It's approximately 9, 2, and 3—$9 million for NIMH, 2 for Drug Abuse and 3 for Alcohol.

ANNIVERSARY OF NIMH

Mr. **Conte**. Did I hear somewhere that we are coming up on a significant anniversary of the National Institute of Mental Health?

Mr. **Trachtenberg**. That's correct.

Mr. **Conte**. Forty years old?

Mr. **Trachtenberg**. That's correct, right.

Mr. **Conte**. Are you planning any events to commemorate that auspicious occasion?

Dr. **Frazier**. Yes, sir, we plan to have a two-day celebration with a two-day scientific symposium with outstanding researchers who have been grant recipients from NIMH and intramural program also—extramural and intramural. We plan also to have a party, and we are going to invite some people—including you and all this committee—and we are looking forward also to having some outstanding persons who have supported mental health through the years, and there will be some awards given.

And it's a very well-thought-out and -planned occasion, I want you to know. We are looking forward to it.

Mr. **Conte**. Thank you, Doctor. I think it's well-deserved.

RESEARCH CENTERS

I would like to focus on the centers program at NIMH. I believe that NIMH runs a small clinical research program of ten or eleven centers similar in intent, if not in size, with the seventy-eight clinical research centers of the National Institutes of Health.

Now, as I look at the center lines of the NIMH budget, I see that you show funding for six competing centers in FY '86 and no competing centers under the budget request for FY '87.

Could you tell me how many centers are coming up for competitive renewal in FY '86 and FY '87?

Mr. **Trachtenberg**. In '87 there are four NIMH centers and one NIDA center.

Dr. **Frazier**. Actually, we have six potential competing renewals—we think they will all submit applications in 1987. Two of the six are included among the 19 in the request. If all of the six come in with good priority scores, we will make every attempt to continue support for the full complement.

It's clear also that we are going to have to look at the entire clinical research center program to evaluate the efficiency, the efficacy, the productivity, and—

Mr. **Conte**. You said "clinical research—

Dr. **Frazier**. Clinical research center.

Mr. **Conte**. Do you think they are worthy of support?

Dr. **Frazier**. I know they are; I have little doubt.

MENTAL HEALTH CLINICAL TRAINING

Mr. **Conte**. With regard to mental health clinical training, this committee has reaffirmed its belief that there continue to be shortages in such areas as services for children, the aged, people in public institutions, rural populations, and so on.

It seems to me the need to provide training in this area is at least as important as the health professions training in the health resources and services area. Even though there is reported to be a lot of doctors, there are still shortages in primary care. I don't really understand why there is a focus on whether to zero out this program. If we don't zero out the other health profession programs, you zero this one out?

Your budget is consistent—you zero both of them out.

But I don't really see why we should consider mental health clinical training any differently from any other health profession training program.

Dr. **Frazier**. I think, Mr. Conte, that there are very definitely some needs in the area of children and certainly in the geriatric areas.

But, in general, this clinical training program peaked out in 1969-1972, at approximately $95 to $100 million a year. It is now $20 million a year, but still the number of students from 1970 to the present has gone up.

So it's pretty clear that the number of trainees entering the fields is proceeding. I think it has slipped a little since 1980, but not significantly.

That's to say that people are entering the field. I think there are other areas where they are gaining support, other than Federal sources. I think also that the opportunities are greater. There is no question that there is a glut in certain other areas.

Mr. **Conte**. Do you agree that there continue to be shortages in mental health personnel in selected service areas, like the young and the old and those in mental institutions, and encouraging more minorities to enter those professions?

Dr. **Frazier**. Yes, I do agree.

Mr. **Conte**. There is a shortage there.

Dr. **Frazier**. Yes.

PAYBACK ISSUE

Mr. **Conte**. What do you think about the payback issue, requiring recipients of clinical training grants to provide service in return once they have graduated?

Dr. **Frazier**. I think the payback mechanism is necessary. It is an effective way to assure that the training dollars are really being used for the purpose intended.

Mr. **Conte**. I understand you have already released some clinical training announcements in FY '86. Some of them told me that two of them had a very short time around.

Dr. **Frazier**. That's correct.

Mr. **Conte**. Two weeks in one case, three weeks in another case. If that's accurate, why such a short notice?

Dr. **Frazier**. The short notice has to do with the fact that we could not announce the program until after final congressional action on the budget; yet, we still had to get the applications back and reviewed in time for the next academic year. The program had been proposed for phaseout in the original President's budget; therefore, we were not in a position to send out announcements any sooner than we did.

NIAAA PATIENT PLACEMENT RESEARCH

Mr. **Conte**. I was pleased to see the report that we requested on patient placement come from NIAAA in a timely fashion, and it appears that some progress in research in this area is now being made. NIAAA recently published a request for a proposal for patient placement research. Do we know how many applications we have? Can you assess the quality of the application at this early juncture? And what amount of funding is anticipated for FY '86–'87 for this patient placement research?

Mr. **Trachtenberg**. I'd like Mr. Archer from NIAAA to answer that.

Mr. **Archer**. Yes, we are beginning to get excellent responses from the request for proposals. We do not have an exact number at this point. They are just now being received and have not yet been reviewed.

We have placed an increased priority, with our staff working with the public and private treatment programs, to encourage additional research grants in this area. We are also working toward the development of exploratory grants for the purpose of further increasing the number of grants which might be received in this area.

It's an area on which we placed priority. We have increased our total commitment by 40 percent between the period of 1985 and

1987. I can provide for the record the specific dollar amounts, if you wish.

[The information follows:]

In 1985, NIAAA used $4.6 million in extramural research funds for projects related to alcoholism treatment issues. We anticipate that this will increase to $5.8 million in 1986 and $6.3 million in 1987.

ADM TREATMENT FINANCING

Mr. CONTE. All right, why don't you do that? I understand that ADAMHA is playing a major role in the development of an appropriate DRG configuration for alcoholism treatment under Medicare, as well as currently looking at Medicare coverage issues, as to whether Medicare should provide better coverage for outpatient treatment or whether it should begin covering inpatient treatment.

Can you briefly describe to the committee the nature of the effort and any progress to date? Will this be a continuing role or just a one-shot affair?

Mr. TRACHTENBERG. I believe it will be a continuing role, subject to funds availability. When Dr. McDonald, the current administrator, came aboard, he, as a clinician, saw a very clear need for ADAMHA to take a role not only in mental health but also in alcohol and drug financing questions.

He's brought in an individual from the Health Care Financing Administration who is at a senior level and is working on a variety of policy issues. NIMH is working rather intensively on the mental health DRG and alternative ways of financing mental health care.

In alcohol we are looking very closely at issues. For instance, we are looking at whether it would be more cost effective for certain kinds of people with alcohol problems to be served in freestanding outpatient facilities rather than expensive inpatient care.

We have a rather active program going, and we are working closely with the Department and with the Health Care Financing Administration.

DIAGNOSTIC APPROACHES

Mr. CONTE. Going back to the report, it indicates that working groups sponsored by NIAAA and the American Psychiatric Association have been working on diagnostic procedures.

Is this in connection with the DSM 4, the new revision of the diagnostic manual? And what work has been done with alcoholism and drug addiction organization in development of the diagnostic approaches?

Mr. ARCHER. Mr. Conte, there are two different matters. One, we have been working closely with the American Psychiatric Association on the diagnostic statistical manual, and to attempt to more appropriately define alcohol and drug dependency.

But, in addition to that, in order to serve the purpose of encouraging additional research in the area of treatment assessment and patient placement, we have formed two additional sub-panels, bringing together outstanding researchers and clinicians to look at the areas in which they can recommend additional methodology and ways to encourage research. We have also brought together a group of individuals as outside experts to assist us in the development of ways to more accurately measure treatment outcomes.

We will then take these two sub-panels and use the information to assist the treatment field in the development of exploratory planning grants and then, hopefully, out of that to develop large-scale clinical trials.

So it's a long-term plan. We have continuing research information which indicates the effectiveness of treatment. What we are concerned about now is to further refine treatment so as to better be able to determine the exact level and type of care each individual needs, so as to serve more people with the same amount of money.

SEVERITY INDEX FOR ALCOHOLISM AND DRUG ABUSE

Mr. CONTE. The report mentioned that research is under way on procedures to measure the severity of alcohol dependence.

Do you think that an agreed-upon and commonly used severity index for alcoholism and drug abuse can realistically be developed and utilized?

Mr. ARCHER. That is a part of what we are testing right now. There are several severity indexes that are available, and, as a part of our research announcement, we have specified these. It's also part of what the measurement panel is looking at, and we will be testing each of these indexes.

The early indications are that it appears that severity indexes or severity scales would be a very useful technique to clinicians, to assist them. We are pleased that part of what we are doing has received worldwide attention; as a matter of fact, we are now part of an international study looking at ways in which we can identify people at the lower end of the severity scale, the people who are just beginning to have problems, before problems become full-blown, and move in more rapidly, and on a more cost-effective basis, to provide the appropriate type of care.

That study is presently being done out of our research center in Connecticut. In addition to that, we have been attempting to look at ways we can identify individuals in the work place, and we have a major research program going on in Boston and in Kentucky, looking at individuals in the work place who will be referred into alternate levels of care, to determine the most appropriate way to go.

Mr. CONTE. I guess I've used my time, Mr. Chairman.

Mr. NATCHER. Mr. Stokes.

MINORITY PERSONNEL IN NIMH

Mr. STOKES. Thank you, Mr. Chairman. Dr. Frazier, I would like to follow up on Mr. Hoyer's questions to you regarding the reorganization.

Information submitted by your staff last year indicated that minorities represented 12 percent of all NIMH employees in branch chief, deputy division chief, and SES positions before the reorganization, and that this percentage would increase to 15 percent under the reorganization.

What is the current percentage of minorities at branch level or higher positions?

Dr. **Frazier**. 12 percent before reorganization, Mr. Stokes, and it's 15 percent after reorganization.

Mr. **Stokes**. For the record, would you please indicate the number and percentage of minorities before and after the reorganization in the following categories: division and SES positions, deputy positions, and the branch chief positions. Also, for the record, please insert a chart showing the number of minority employees by ethnic category for grades 13 through 15 and SES positions for each year from 1979 to the present.

Can you do that?

Dr. **Frazier**. Be glad to do that, Mr. Stokes—surely will.

[The information follows:]

NIMH MINORITY STAFF IN EXECUTIVE POSITIONS BEFORE AND AFTER REORGANIZATION

Category	Before Reorg.	After Reorg.	Change
Senior Executive Service:			
Deputy Institute Director	--	1	+1
Associate Institute Director	1	2	+1
Division Director.........	1	--	-1
Subtotal, SES...........	2	3	+1
Other (Gen. Schedule) Positions:			
Office Director...........	1	--	-1
Deputy Associate Institute Director................	1	1	--
Deputy Division Director..	--	1	+1
Branch Chiefs.............	3	4	+1
Total in Executive Positions	7	9	+2
NIMH Headquarters Employment (FTE).........	433	433	xx
Percent of NIMH Headquarters Employment...............	1.6%	2.1%	+0.5%

TOTAL NUMBER OF MINORITIES IN NIMH BY ETHNIC CATEGORY

Minority Staff by Reporting Date A/

	10-2-82	10-1-83	9-29-84	3-30-85	2-28-86
GS-13 through GS-15:					
Black	20	19	16	15	13
Hispanic	4	3	2	2	2
Asian	6	6	6	6	6
Indian	0	0	0	0	0
Subtotal	30	28	24	23	21
Senior Executive Service:					
Black	1	1	1	1	2
Hispanic	1	1	1	1	1
Total	32	30	26	25	24

A/ The Public Health Service Work Force inventory profile reports data only as far back as 1982.

MONITORING OF MINORITY-RELATED RESEARCH

Mr. **Stokes**. Now, how will program administrators within NIMH be held accountable for maintaining a strong NIMH commitment to minority-related research throughout all the NIMH research and training programs?

Dr. **Frazier**. We hold our programs accountable in three ways. First, as part of the reorganization, we consolidated all research training and all minority research under one chief and one branch. And that means that all the programs are together so we can keep a very strong monitoring control of it.

This is not to say, however, that all research by minorities and about minority subjects are within that branch and that division, because the vast majority of NIMH minority research by minorities on minority subjects is across the board through the regular channels of research.

However, that leads us to the second accountability tool. We have an Associate Director for Special Populations whose responsibility is to be certain that every division and every office, every branch, every section in NIMH is attending to our commitment to minority research and minority research training.

Third, there is a minority-related goal written into every single division chief and office chief performance plan. I personally review their performance periodically to be certain that what they are committed to is being carried out.

Mr. **Stokes**. How about at NIDA and NIAAA?

Mr. **Trachtenberg**. Let me just respond to that. What Dr. Frazier is referring to is a minority strategy that was established at the ADAMHA level and issued recently by Dr. Macdonald. The requirement, for instance, for the performance plan is in both NIDA and NIAAA executives' plans.

It's a very broadly based commitment that, in times of fiscal constraints, we are not going to jeopaidize minority programs.

SUPPORT OF BLACK COLLEGES AND UNIVERSITIES

Mr. **Stokes**. Can you tell us what goals have been established to increase research and research training support to historically black colleges and universities?

Mr. **Trachtenberg**. We have increased our goal for support of historically black colleges and universities this fiscal year, and we increased it substantially, and we are working to meet that goal.

In terms of minority access to research careers and the other minority fellowship programs, they have taken a percentage cut, as a result of the sequestering, but other parts of the research training program took a bigger part of the reduction than the minority research training programs.

Mr. **Stokes**. Feel free to expand upon this in the record for me, if you would.

Mr. **Trachtenberg**. I would be happy to do so, Mr. Stokes.

[The information follows:]

HISTORICALLY BLACK COLLEGES AND UNIVERSITIES

The Department issued guidance in FY 1985 on ways to increase our Historically Black Colleges and Universities (HBCUs) activities. This guidance recommended that we:

Involve the private sector in devising methods to increase our support to Black colleges.

Provide greater technical assistance activities to HBCUs.

Plan to award at least 3 percent of obligations to higher education institutions to HBCUs.

To support the HBCU program, ADAMHA expended approximately $2 million dollars in fiscal year 1985. Our projection for fiscal year 1986 is $2.1 million.

In fiscal year 1985, NIMH sponsored a workshop on grantmanship for 37 HBCU professors. The purpose of this workshop was to educate new faculty researchers from HBCU on funding sources and eliminate barriers to HBCU participation in NIMH programs.

In conjunction with the National Alliance of Business, a vigorous program has been implemented for ADAMHA staff to visit selected HBCUs to inform faculty and students about careers and research opportunities in the alcohol, drug abuse, and mental health fields.

TASK FORCE OF BLACK AND MINORITY HEALTH

Mr. STOKES. Did the Alcohol, Drug Abuse and Mental Health Administration participate in the development of former Secretary Heckler's task force report on black and minority health?

Mr. TRACHTENBERG. Yes, Mr. Stokes. I was the chairman of the subcommittee that prepared the report on homicide, accidents, suicide and other areas of violent conduct.

I think the report we issued in this area is going to be and has already been seen as a very important statement in the area.

In addition, we have a small group of very senior executives, of which I am one, that is helping the new chief of the Office of Minority Health, located with the Office of the Assistant Secretary of Health, to find ways to make the office effective and operational as quickly as possible.

As you know, Dr. Herb Nickens, a former member of the National Institute of Mental Health, is the director of the Office of Minority Health.

Mr. STOKES. I thought that Secretary Heckler performed a real service to the nation in releasing that report. The report included excellent research. Of course, we are all interested in seeing that there is follow-up regarding both the Office of Minority Health that she established and the recommendations which were included in that report.

We will be monitoring this as you go along to ascertain what is in fact being done.

NIMH MINORITY RESEARCH

Mr. Trachtenberg, in an October 1985 letter to me from Dr. Macdonald, he responded to my concerns regarding the NIMH reorganization. He indicated that in fiscal year 1984 NIMH funded 147 grants totalling $22.5 million in which minority groups were studied. However, in the hearing record, in response to one of my questions, he indicated that in fiscal year 1984 NIMH spent $18.4 million on minority population concerns, with $11.4 million of that on research grants.

I would appreciate it if, for the record, you would tell us which are the correct figures.

Mr. Trachtenberg. We will verify that.

[The information follows:]

Dr. Macdonald's response to your concerns regarding the NIMH reorganization in October 1985 was correct. In fiscal year 1984, NIMH funded 147 grants totaling $22.5 million in which minority groups were studied. The figures provided for last year's hearing record were also correct but were based on only a portion of the criteria used in gathering minority data. Our Associate Director for Special Populations has reviewed the definitions used in gathering data on our minority-relevant activities and developed a standard so that all Institute data is now comparable.

Mr. Stokes. Can you tell us what your figures are for fiscal year 1985 and the estimates for 1986 and 1987?

Dr. Frazier. For minority research in '85, there were 144 grants at $21.7 million. This represents all grants with any degree of minority relevance. We expect to remain stable at this level in 1986 and 1987. For training, we had 90 grants and a total of $5.0 million in 1985. Because of the proposed rescission and phase-out of clinical training, the totals are expected to decrease to 17 awards and $1.7 million in 1986, and 14 awards and $1.5 million in 1987.

Mr. Stokes. What are the comparable figures for both NIDA and NIAAA?

Mr. Trachtenberg. We will do that for the record.

[The information follows:]

The following table shows amounts comparable to NIMH for minority research and research training grants in NIDA and NIAAA:

	1985		1986 Revised		1987	
	Number	Amount	Number	Amount	Number	Amount
Extramural research:						
NIDA	9	$1,643,000	9	$1,529,000	10	$1,700,000
NIAAA	10	1,066,000	11	1,083,000	11	1,091,000
Total	19	2,709,000	20	2,612,000	21	2,791,000
Research training (MARC): [1]						
NIDA	1	86,000	1	84,000	1	77,000
NIAAA	2	114,000	1	84,000	1	77,000
Total	3	200,000	2	200,000	2	154,000
Grand total	22	2,909,000	22	2,780,000	23	2,945,000

[1] MARC undergraduate awards are made through NIMH with both NIDA and NIAAA contributing 10 percent of the total

RESEARCH TRAINEES

Mr. Stokes. All right. How many individuals will be supported on institutional training grants in fiscal years 1986 and 1987?

Mr. Trachtenberg. In research training the total number will be 999 in FY '86 although that number goes down, because of the sequestering, to 959. In '87 trainees are further reduced to an amount proportionate with the reduction in the number of new and competing research grants, to 882.

Mr. Stokes. The National Institutes of Health have undertaken specific initiatives to increase the number of under-represented minorities supported through institutional training grants.

What steps has your agency taken?

Mr. Trachtenberg. We didn't have the funds to carry out the activity that NIH does, although I commend them for what they have done. Our programs, our major programs, continue to be the minority research scholar program, the minority fellowship program, and the minority access-to-research-careers program, which is both undergraduate and graduate. We are seeing some really exemplary results in that MARC program.

Mr. Stokes. It has been a good program over the years. I have just one further question.

MINORITY RESEARCH PROGRAMS

I would like you to provide the fiscal year 1985, 1986, and 1987 funding estimates for the Minority Biomedical Research Support Program, the Minority Access to Research Careers Program, the Minority Fellowship Program, including clinical training, and the Minority Research and Development Centers.

Mr. Trachtenberg. We have that information and we will be pleased to provide it for the record.

Mr. Stokes. If you want to give it now, you can.

Mr. Trachtenberg. Let me give it for the record.

[The information follows:]

FUNDING FOR SELECTED MINORITY PROGRAMS

Program	1985	1986	1987
Minority biomedical research support	$1,244,000	$1,200,000	$1,200,000
Minority access to research careers	855,000	855,000	855,000
Minority fellowship	[1] 1,772,000	722,000	722,000
Minority research and development centers[2]	1,439,000	1,559,000	1,559,000

[1] 1985 includes $1,050,000 under the Clinical Training program which is proposed for rescission in 1986 and phase-out in 1987

[2] These awards are R01's (Project Grants).

Mr. Stokes. Thank you. Thank you, Mr. Chairman.

Mr. Natcher. Mr. Hoyer?

Mr. Hoyer. Doctor, when you give that answer for the record, maybe Dr. Frazier can comment as well on the criteria used in fiscal year '86 and tell the committee whether there are any changes in the process proposed in the fellowship program for '87. We were concerned about that last year and made some comments on it last year.

[The information follows:]

Priority scores and the history of program success will be the primary criteria used to determine funding of the Minority Fellowship Programs in FY 86. As a part of the overall reorganization of the Institute, all minority focused research training has been consolidated within the Minority Research Resources Branch in the Division of Biometry and Applied Sciences. An Institute Task Force is reviewing all of our efforts to improve and increase the training of minority persons for research careers in mental health. The Task Force will develop options that will be presented to the National Mental Health Advisoy Council for their consideration in September, 1986. Council's recommendations concerning the allocation of awards and specific criteria will be the basis for FY 87 allocations.

FUNDING FOR ALCOHOLISM RESEARCH

Let me go back, to funding for Alcoholism Research if I can, I really am concerned about the alcohol problem, because it gets papered over. And the reason it gets papered over, in my opinion, is because so many more people use alcohol than use drugs. We indeed have a large drug abuse problem but when we talk about the alcohol abuse problem people shrug and say, well, we all do that, so it's not a problem if we do it.

We are proposing to spend $14 million essentially less on alcohol research and research training, direct operations, than we do on drug abuse.

Why is that, if we conclude that the alcohol problem is, if certainly not larger, equally large? The cost is approximately double, according to your figures.

Why do we then spend less on alcohol abuse than we do on drug abuse?

Mr. **Trachtenberg**. Well, I think you have to start from where these programs began. Both alcohol and drug abuse are really very small programs. For example, NIAAA in 1981 it had twenty-nine new and competing grants; it was absurd how low the number was. That number has been steadily increasing over the years, and, as you know, the institute was at one hundred new and competing grants in '86, although it goes down to 74 in '87.

There has been a considerable push, particularly in the alcohol area, to try to slowly build despite an atmosphere of tight fiscal constraints. At the same time, a number of people feel that NIMH is not growing fast enough and I would probably agree there except for the budgetary environment. As a percentage, NIAAA has been gowing—given it's small size in terms of the base—has been growing a little bit faster than NIMH.

But I share your concern; it's an insidious problem.

Mr. **Hoyer**. Mr. Trachtenberg, I'm glad you share my concern, but my question was—and I am not quibbling with you, I understand what you've said and I agree with that—why, though, do we spend so much more on drugs? Is the problem bigger notwithstanding the fact that the money loss is 40 percent higher? The loss to society, the consequences to society, are really, from my perspective, a lot greater due to alcohol abuse. And I think because of societal reasons we don't elevate it. It's a lot easier to say people who use cocaine are a much greater problem because two-thirds of us don't use cocaine and perhaps have a particular perspective.

But why do we spend more on drugs than we do on alcohol?

Mr. **Trachtenberg**. The point I was trying to make is that budgets are built on a historical basis, and when you start small it takes you longer to grow up.

I think NIDA, except again for the situation that it is in, is also under-funded. If this was—

Mr. **Hoyer**. What was NIDA, for instance, in 1981?

Mr. **Trachtenberg**. In '81?

Mr. **Hoyer**. Yes.

Mr. **Trachtenberg**. In '81 they had 79 new and competing grants and 131 in '85.

Mr. Hoyer. So what you are saying is that drug research was bigger in '81 and alcohol is catching up because it's our perception that it is a serious problem. So I will try to do that, sir.

Can I ask two more questions, sir?

Mr. Natcher. Go ahead.

RESEARCH ON SEXUAL VICTIMIZATION

Mr. Hoyer. I was very involved at the state level on sexual offense legislation, both in terms of the criminal aspect of it, the civil aspect and the treatment of it.

What has been the impact of the recent phasing-out by NIMH of the National Center for the Prevention and Control of Rape? And the corollary: Will NIMH still be supporting research on psychological consequences of sexual victimization?

Dr. Frazier. Mr. Hoyer, there has been no reduction in research; we have maintained good research in the area of rape. The Rape Center was phased out, but the rape grants were moved to the Anti-Social and Violent Behavior Branch in the Division of Biometry and Applied Sciences.

I talked with the head of that branch the day before yesterday, and he told me that he has a number of extraordinarily fine grants and new researchers.

We have a number of grants in the area of rape as well as a number of grants on the sexual abuse of children and on the assessment and prediction of child abuse.

Mr. Hoyer. Thank you. If you could provide me with some additional information on that, I'd appreciate it. I also have some questions on St. Elizabeth's, but I will submit them for the record.

[The information follows:]

NATIONAL INSTITUTE OF MENTAL HEALTH

REPRESENTATIVE PROJECTS RELATING TO RAPE AND CHILD ABUSE

The material which follows describes three representative areas in which the National Institute of Mental Health supports studies relating to rape and child abuse.

1. IMPACT OF SEXUAL ABUSE ON CHILDREN

Research Development: Preliminary findings from an NIMH-supported study of child sexual abuse victims indicate that shortly after their last assault victims can be clearly differentiated from nonvictims on a 110-item checklist employed by the nonoffending parent. Although all 12 clinical dimensions of the checklist yield significant differences, those differentiating most clearly are poor concentration, somatic complaints, nervous/emotional problems, and post traumatic stress symptoms.

Explanation: Dr. Jon Conte and his associates studied the effects of sexual abuse on a sample of 360 sexually abused children at the Harborview Medical Center in Seattle and a comparison group of 300 nonvictimized children. Only children for whom there was a positive finding of sexual abuse were included in the victim sample. The victimized children had been exposed to a variety of sexual behaviors ranging from fondling to digital penetration of the vagina, vaginal penile intercourse and oral sex, with the average victims experiencing three of the four classes of offensive behavior. Perpetrators were largely members of the child's family (51%), acquaintances or babysitters (37%) rather than strangers (4%). Most of the assessments were conducted within six months of the last incident of sexual abuse.

The group profiles that emerge from this parent-employed instrument are considerably more complex than those that emerged from the investigators' study of assessments of child victims by clinical social workers employing a 38-item checklist reflective of impact reports in the clinical literature. On clinical assessment, a fifth of the children exhibited none of the symptoms thought to be characteristic of sexual victimization. The most common problem was low self esteem, and the the number of recorded symptoms largely reflected the absence of a supportive relationship with a nonoffending adult or sibling, the child's age, a nonoffending parent who disbelieves the child and an offender who denies the assault.

Implications: Although professionals have been concerned about the potential negative effects of childhood sexual abuse since Freud's observations of hysterical adults, sexual abuse of children was not regarded as a serious problem by most professionals or the public until the past few years. One of the major tasks has become the facilitating of professional recognition of the range of mental health and related problems that can result. This study documents the extent to which a traditional clinical perspective can miss the wide range of psychological effects in victimized children. It also demonstrates the broader range of dysfunction that can be identified through parental reporting utilizing a checklist developed from two child assessment instruments widely employed in the evaluation of child behavior problems generally.

2. ASSESSMENT AND PREDICTION OF CHILD ABUSE

Research Development: An NIMH grantee has developed a highly reliable assessment instrument to assist in the screening of suspected cases of physical child abuse.

Explanation: Each year more than 1,000,000 cases of supected child maltreatment are reported in the United States. When such reports are made, protective service workers in each State are legally required to investigate and render a decision as to the occurrence of physical child abuse and/or neglect. To assist in this decision-making with respect to physical child abuse, NIMH provided support to Joel Milner, Ph.D. (Western Caroline University) for the refinement and validation of a highly reliable screening instrument known as the Child Abuse Potential (CAP) Inventory. Development of this instrument was based on a thorough review of the mental health and related literature on factors related to child abuse. The CAP has been specifically designed for use by protective services workers is brief, easy to understand, and easy to administer and score. A detailed manual has been prepared in order to instruct protective service and other workers in the proper use of the CAP.

Implications: Although many types of child abuse screening instruments currently exist, their reliability and validity are generally unknown. Development of the CAP was supported by NIMH in order to impart greater reliability and objectivity to the decisions by protective service workers that can have profound impacts on the welfare of children and families. This screening instrument (CAP) can also be used to evaluate the effectiveness of various interventions aimed at reducing risks of physical child abuse.

3. NATIONAL SURVEY OF FAMILY VIOLENCE

Research Developments: The first National Family Violence Survey was funded by NIMH in 1975 to obtain the first reliable national data on the prevalence of various types of intra-family violence in the United States--viz., violence towards wives, husbands, children, parents, and siblings. In 1985 a second national survey was funded and the research is providing reliable data on changes in family violence that have occurred during the past decade. Significantly, the resurvey includes several groups that were omitted from the initial study--children under three years of age and single parents; there has also been an over-sampling of minorities (Blacks and Hispanics).

Explanation: Results to date (based on data only from two-parent households with children aged 3-17) are very encouraging. The rate of severe physical abuse of children has decreased 47 percent since 1975, while the rate of severe wife-beating has decreased by 21 percent. Only rates of wife-to-husband violence have remained relatively unchanged. (Severe abuse is defined as acts that have a high probability of causing injury--kicking, biting, punching, hitting with an object, beating, and threatening with or using a knife or gun.)

The researchers, Drs. Murry Straus of the University of New Hampshire and Richard Gelles of the University of Rhode Island, believe that the reported decreases in severe child abuse and wife-beating during the past decade can be attributed to a number of factors, including: (i) changes in family structure involving a rise in average age at the time of first marriage and a decline in the number of children per family; (ii) improvements in the national economy involving improved employment opportunities for women; (iii) improved alternatives for battered women, such as "safe houses" or "shelters" that were almost non-existent 10 years ago; (iv) greatly increased attention by the media to problems of family violence; and (v) improved law enforcement policies and procedures.

Implications: From the perspective of the welfare of children and families, the preliminary results of the 1985 survey suggest that efforts over the past decade to do something about the ancient and seemingly intractable problems of child abuse and wife-beating have achieved some measure of success. Still, however, family violence remains a major national problem. Moreover, as noted earlier, data thus far analysed do not include "high-risk" infants and children in single-parent families. These and other data will become available as the results are further analyzed over the next two years.

Mr. Natcher. Mr. Trachtenberg, we want to thank you and your associates for appearing before our committee at this time on behalf of your budget request for fiscal year 1987. This has been a good hearing.

Mr. Conte, I yield to you.

Mr. Conte. I am going to submit questions for the record. I just want to compliment you, Dr. Frazier, for your written statement on St. Elizabeths. It is probably the best I've ever read, and I guess it reflects that after years of confusion the Hospital's future is now carefully set out—hopefully for good.

Dr. Frazier. Thank you very much.

Mr. Natcher. Thank you.

[The following questions were submitted to be answered for the record:]

DECREASE IN CENTERS

Mr. Natcher. Let's turn to your research centers program. Your justifications show 35 centers in 1985, 36 in 1986, and 31 in 1987. Are the 5 centers being closed in your budget for 1987 being terminated because of concerns about the quality of their research or strictly because of funding limits?

Mr. Trachtenberg. Based on their current performance, we have no reason to be concerned about the quality of the performance of these centers. Four of them are supported by NIMH and one is funded by NIAAA. All five are now in their last year of support under their current continuation cycles. They will need to apply for renewal on a competing basis in 1987 if they wish to continue to be funded. We have not seen their applications yet and are therefore not in a position to make decisions based on their priority scores. For this reason, when we constructed the budget, we decided to show the lower number of centers at full funding levels. However, if all five apply for renewal and receive good priority scores, we will do our utmost to continue our full complement of 36 centers within the available funds.

ALLOCATION OF ADDITIONAL FUNDING

Mr. Natcher. Mr. Trachtenberg, the original 1986 appropriation provided $332 million for research activities at the three institutes, excluding AIDS. If we assume an inflation rate of 5% for research, it would take $348.9 million to maintain this level of activity in 1987. This is $30 million more than requested by the President. For the record, we want you to tell us how you would allocate an additional $30 million among the institutes and among the different mechanisms.

Mr. Trachtenberg. Should we be allowed an additional $30 million for our research program we would obligate in accordance with the following chart:

SPREAD OF ADDITIONAL $30 MILLION IN 1987
(dollars in thousands)

	NIMH	NIDA	NIAAA	Total
1. Support all research center renewals......	$1,624	$1,504	---	$3,128
2. Address shortfall for continuation grants..	835	442	189	1,446
3. Provide council level recommendation for new grants...........	3,577	1,839	1,167	6,583
4. Provide new funds for Other Research Mechanisms...........	7,457	600	1,500	9,557
5. Support 900 research trainees.............	---	345	200	545
6. Increase new/competing research project grants to 515...............	3,876 (27)	2,146 (14)	2,699 (26)	8,721 (67)
	17,369	6,876	5,755	30,000

PROTECTION AND ADVOCACY

Mr. Natcher. Mr. Trachtenberg, the President's budget includes rescissions in mental health programs which would eliminate three programs - clinical training, community support, and protection and advocacy. As you know the $10 million approved by the Congress for the protection and advocacy is conditional on passage of an authorization. This legislation is expected to be sent to the President shortly. Tell us why you are opposed to this program.

Mr. Tractenberg. Mr. Natcher, the Alcohol, Drug Abuse, and Mental Health Administration does not oppose the program as such. The request for rescission that appears in our budget follows from the fact that authorizing legislation has yet to be passed or enacted.

We take note that four States - Michigan, Ohio, New Jersey, and North Carolina - have already established similar programs on their own initiative.

Mr. Natcher. According to the authorizing committees a similar program for the mentally retarded has worked well for more than 10 years. Did you review the program for the developmentally disabled before deciding to oppose this new effort?

Mr. Trachtenberg. Mr. Natcher, as I indicated previously, authorizing legislation has yet to be passed and enacted. The request for rescission flows from this. It is not based on any conclusions we have reached about a similar program for the developmentally disabled.

Mr. Natcher. Will your agency recommend to the President that he veto the protection and advocacy bill if it clears the Congress?

Mr. Trachtenberg. We cannot speculate what advice the Secretary might give the President with regard to this legislation. The Administration has not opposed the specific bill to date.

CLINICAL TRAINING

Mr. Natcher. Between Fiscal Year 1980 and 1986 Federal support for clinical training declined from $72.1 million to less than $20 million. What has been the effect of this reduction on enrollments in programs to train mental health personnel?

Mr. Trachtenberg. In general there has been little effect. The last year for which we have enrollment data is 1984. Comparing that year with 1979-1980 we see that the number of psychiatric residents and nurses in graduate training has increased somewhat. In psychology, it has remained level, and in social work it has decreased. Enrollment in all of the disciplines increased sharply prior to 1980, so that a leveling-off in recent years could be construed to reflect a measure of success in meeting demand for these disciplines.

Mr. Natcher. Insert in the record at this point a table for each of the last six years showing total Federal support for clinical training, the proportion going to each of the core disciplines, the number of students supported with Federal funds, and the total enrollment in each discipline.

Mr. Trachtenberg. We have information for 1979 through 1984. The data for 1985 has not been made available yet.

NIMH CLINICAL TRAINING BUDGET, STIPENDS AWARDED, AND GRADUATE ENROLLMENT IN THE MAJOR MENTAL HEALTH DISCIPLINES, FY 1979-1984
(Dollars in thousands)

Discipline	1979	1980	1981	1982	1983	1984
Psychiatry, Percent of Total	32%	32%	33%	32%	30%	32%
No. Stipends Awarded	98	152	107	50	53	45
Residency Enrollment	4,407	4,518	4,681	4,866	5,109	5,312
Psychology, Percent of Total	14%	15%	15%	15%	16%	16%
No. Stipends Awarded	1,553	1,120	946	726	324	371
Graduate Enrollment	39,786	40,636	40,691	41,098	41,129	40,650
Social Work, Percent of Total	15%	16%	16%	17%	14%	14%
No. Stipends Awarded	784	764	719	565	255	304
Graduate Enrollment	18,351	17,947	17,420	16,053	15,080	15,073
Nursing, Percent of Total	11%	11%	12%	13%	12%	12%
No. Stipends Awarded	913	809	817	640	152	176
Graduate Enrollment	12,796	13,820	15,834	16,425	16,945	19,537
Multidisciplinary, Percent of Total	--	--	--	--	2%	3%
Total Funds, Clinical Training	74,287	72,103	62,433	42,299	20,093	21,000
Total Funds, Discip. Trng.	53,487	53,356	47,499	32,510	15,048	16,238
Percent of Total	72%	74%	76%	77%	75%	77%

Sources:
1. Psychiatry resident data are from the American Psychiatric Association.
2. Psychology graduate enrollment data from the National Science Foundation.
3. Nursing graduate enrollment data from the National Science Foundation. Psychiatric nursing enrollment is not available, but recently this area has accounted for about 15% of graduate nursing enrollment and graduations.
4. Social Work data are from publications of the Council on Social Work Education.
   Specialization areas of social work students are not given.

Mr. Natcher. How much money would be required in FY 1987 if Congress decided to fund continuation grants only in the Clinical Training program?

Mr. Trachtenberg. If we assume that the 1986 program is funded at the sequestered level of $19,140,000, the 1987 continuation cost would total $14,250,000 for 240 projects. However, we are proposing that the Clinical Training program be rescinded in 1986 and that there be no future funding. NIMH has supported this program for nearly 38 years. During this period, there has been a major improvement in both the supply of mental health professionals and the capacity of the training community to continue to function without Federal support. We believe that the Clinical Training program has reached the point where it can and should draw its support from student loans and non-Federal sources.

STATUS OF SEH TRANSFER

Mr. Natcher. Mr. Trachtenberg, let's return to your budget request for St. Elizabeths Hospital. Congress approved legislation two years ago which provides for the transfer of the facility to the District on October 1, 1987. What is the current status of efforts to prepare the hospital for transfer?

Mr. Trachtenberg. A great deal has been accomplished in preparation for transfer:

- A Preliminary System Implementation Plan has been completed by the Mayor's Mental Health Systems Reorganization Office and has been submitted to the District of Columbia City Council for review. This plan describes a comprehensive approach to the delivery of community based public mental health services to all residents of the District of Columbia. It contemplates reasonable reductions in the chronic long term adult inpatient population of Saint Elizabeths Hospital and substantial increases in program support in the areas of adult ambulatory care, child and adolescent services and forensic psychiatric services. Over 150 Saint Elizabeths Hospital staff participated in the development of this comprehensive plan.
- Preliminary draft staffing patterns have been developed for each of the service components described in the Preliminary System Implementation Plan. These staffing patterns have been distributed to all interested parties within the system for analysis and review.

- Detailed analyses of the physical facilities located on the campus of Saint Elizabeths Hospital have been completed. These analyses include a full physical plant audit mandated by the Act and the report of a consultant to the Mental Health Systems Reorganization Office. The framework for site planning and development of alternative strategies for physical plant utilization have now been laid.

- An audit of the financial statements of Saint Elizabeths Hospital has been completed pursuant to the requirements of the Act. The results of the audit were the issuance of a unqualified opinion that the financial statements fairly represent the financial position of the Hospital and that no material weaknesses were identified in the internal control practices of the Hospital.

- The Mayor has created a Reorganization Implementation Team and charged it with the responsibility for finalizing transition plans and implementing the System Implementation Plan. This team, made up of high ranking officials of the District of Columbia Department of Human Services, Saint Elizabeths Hospital, and the Department of Health and Human Services has already begun the process of transition which will allow uninterrupted delivery of quality services during this important transition period.

In FY 1987, our goals and objectives are directed primarily at completion of preparations for transfer. Specifically we hope to accomplish the following:

- Functional reorganization of Hospital inpatient programs to achieve alignment with the System Implementation Plan.

- Transfer of outpatient treatment responsibility from Hospital-based programs to existing community mental health centers, with appropriate reassignment of clinical staff to these centers.

- Completion of analysis of physical plant requirements to assure consistency with the District's physical plant utilization plan and redirection of remaining capital improvement resources to renovations required under the Plan.

- Completion of all necessary changes to the Preliminary System Implementation Plan consistent with the timetable contained in the legislation.

- Finalization of program staffing patterns preparatory to the transfer of employees to District government management on October 1, 1987.

FEDERAL OBLIGATION FOR SUPPORT OF SEH

Mr. Natcher. What will be the Federal government's financial obligation to the hospital after transfer is accomplished?

Mr. Trachtenberg. Several provisions of the transfer bill assigns financial responsibility to the Federal Government following transfer of the hospital from Federal to District management. First, financing provisions of the bill establish continuance of the 10 year plan authorized for appropriation to the District government in decreasing amounts:

$30 million - FY 1988
$24 million - FY 1989
$18 million - FY 1990
$12 million - FY 1991

Authorization is further provided for Federal payment of a special subsidy to the District of Columbia:

$25 million - FY 1986
$35 million - FY 1987
$30 million - FY 1988
$20 million - FY 1989
$15 million - FY 1990
$10 million - FY 1991

Several other specific provisions of the law assign financial responsibility to the Federal Government for the following:

- repairs and renovations to the physical plant and facilities at the hospital to be utilized by the District to meet applicable code requirements or standards;
- maintenance of all other facilities and infrastructures of the hospital not assumed by the District on October 1, 1987;
- funding for retraining of hospital employees for employment in the District's system;
- funds for severance pay for RIF'd employees;
- unassigned liabilities of the hospital prior to transfer as determined by the final financial audit.

Preliminary work is in progress to develop the budget requests with major focus on capital improvements associated with the D.C. Preliminary Plan for construction and renovation in compliance with code requirements. Several aspects of the budget will undoubtedly require intensive negotiations with the District to arrive at reasonable assignment of responsibilities between the Federal and District of Columbia Governments.

DISTRICT OF COLUMBIA SUPPORT FOR SEH

Mr. Natcher. What amount of funding are you anticipating from the District in 1987 and is it included in their request to the Congress?

Mr. Trachtenberg. The District government has included $71.2 million in its budget for payments to Saint Elizabeths Hospital. This amount is $5.6 million below the $76.8 million anticipated in the FY 1987 budget proposal for SEH. This difference will be discussed with the District.

REDUCTIONS IN SEH PATIENT LOAD

Mr. Natcher. The preliminary plan developed by the District calls for a dramatic reduction in both the number of patients and the number of staff. Would you describe for the Committee your understanding of these plans?

Mr. Trachtenberg. It is my understanding that the number of patients to be served in the District plan for the new mental health system for the District of Columbia, in fact, will increase over the present number served by both Saint Elizabeths Hospital and the District of Columbia. It is correct, however, that the number of patients receiving inpatient services at Saint Elizabeths Hospital will go down significantly. This reduction in inpatient census will be accomplished in accord with court mandates in the Dixon case and will result in patients being in either nursing homes, supported apartment living or in other types of community facilities based on each individual patient's set of clinical needs. Although it may be difficult to accomplish the outplacement of the patients at the rate described in the District plan, I think that it is important to make every attempt to meet that rate of out-placement for it will result in more appropriate care being provided to the patients. With regard to the reduction in the number of staff it is important to note where the reductions will come. Most of the reductions will result from out-placement of adult patients into community facilities and through provision of acute care in general hospitals. It is anticipated that some staff will be picked up by contractors to the District of Columbia who are providing either acute services or services for chronic patients in the community. Likewise, some staff will be transferred from their current inpatient duties to outpatient duties. In addition, the number of persons who will be necessary to provide services for children will increase significantly as the children's service system expands. Overall, the reduction in staff size, both the direct clinical staff and necessary support staff, can be accomplished without a reduction in the quality of patient care if the goals for changing the locations of patient care are met.

OUTPLACEMENT

Mr. Natcher. In 1983 the District entered into an agreement to "outplace" a large number of patients into community facilities. Was the District able to fully comply with this agreement?

Mr. Trachtenberg. The District of Columbia has substantially complied with its 1983 agreement to outplace 250 patients into community facilities. More than 150 patients were placed into regular nursing home beds, and 50 "difficult to place" community residential facility patients were placed into community residential facilities through the use of two contractors to provide case management and additional necessary services. For a third group of 50 "special placement" nursing home patients the District is still in the process of making arrangements for renovations at D.C. Village to accommodate these patients. Completion of its obligation for these patients as well as providing for additional special placement nursing home beds is included in the District's plan for the new mental health system.

DIXON CASE

Mr. Natcher. What is the current status of the Dixon court case regarding the deinstitutionalization of patients from the hospital?

Mr. Trachtenberg. Saint Elizabeths Hospital and the District's Mental Health Services Administration continue to meet the requirements for deinstitutionalization of hospital patients as agreed to in the Dixon v. Bowen Final Implementation Plan. The court ordered moratorium on the transfer of hospital outpatients to the District's community mental health centers remains in effect. Both the Federal and District defendants agreed and received the Court's approval to extend annual payments to the Plaintiffs' Implementation Monitoring Committee. Payments are made to the Mental Health Law Project (MHLP).

Saint Elizabeths Hospital continues to seek ways to maintain and improve, when possible, the quality of programs involving the deinstitutionalization of patients from the hospital. The Hospital's clinical divisions emphasize specialized psychiatric rehabilitative care services and programs. A primary goal is the preparation of patients for outplacement, through one to one therapy, group or family therapy and progression from one program to another program which requires more activity of daily living skills. Patients evaluated to be long term are reviewed by a treatment team at least quarterly. Each treatment plan includes a statement regarding outplacement plans.

One program at SEH related specifically to deinstitutionalization is the Positive Reinforcement Outplacement Program (PROP) which involves the training of Community Residential Facility operators in dealing with hard-to-place patients. One recent program developed with the Mental Health Services Administration and a community-based agency resulted in the placement of inpatients into the community, all of whom had previously experienced several failures with community living. This particular program has been extremely successful. The hospital has contracted with several community-based agencies to provide socialization services, transitional living services and transitional employment services for hospital patients. During March, 1985, the hospital approved and put into operation a program which provides up-front money for room and board, with specific guidelines for use by the hospital patients. This program will assist staff in helping patients return to the community without waiting from one to two months for the required finances.

Special nursing care and regular nursing care placements are not developing as rapidly as we would hope. Nursing care beds for special placement are not completed and the accessibility of regular nursing care beds is limited because the number of potential users exceed the number of available beds. Several options to access the regular care nursing beds are under consideration.

A comprehensive mental health program which emphasizes a community-based system has been developed in accordance with Public Law 98-621. A Preliminary System Plan has been developed and forwarded in compliance with Public Law 98-621. In the Plan, deinstitutionalization of patients from Saint Elizabeths Hospital will continue. Continuity of care is emphasized and safeguarded.

USE OF SEH LAND

Mr. Natcher. The Mayor has been quoted as saying that the city is seriously considering the sale of land now occupied by the hospital. Does the transfer legislation allow the transfer of the property?

Mr. Trachtenberg. The transfer legislation stipulates that the Mayor is required to submit a plan to the Congress on or before October 1, 1991 as to the proposed use of the remainder of St. Elizabeths property determined not necessary for mental health purposes. The transfer legislation stipulates that such plan must be consistent with the comprehensive plan for the national capital, have been reviewed by appropriate Federal, regional and local authorities and submitted to relevant committees of the House and Senate. If the master plan is approved by Congress as a law, the property will be transferred without cost to the District government. The District's Preliminary Implementation Plan identifies facilities on the East-side campus only as necessary for mental health service delivery. While we are not aware of any statements by the Mayor or other city officials concerning possible sale of hospital land, city officials concerned with development of the Mental Health System Plan have advised that the Mayor has established a task force to review options for West-side grounds, under the leadership of Mr. Curtis McClinton, Deputy Mayor for Economic Development and Mr. David Rivers, Director of the District's Department of Human Services.

FACILITY STUDY

Mr. Natcher. Public Law 98-621 requires a full survey of the facilities prior to transfer. We have been told informally that this study may identify as much as $40 million in construction needs. What can you tell us about the results of this study?

Mr. Trachtenberg. We are most pleased to report that the required physical plant audit was completed on January 1, 1986. The study encompassed an extensive inventory of 340 acres, 105 buildings, and five miles of roadways and the hospital's utility systems for steam, water, gas, electrical, chilled water, sanitary and storm sewers. This analysis and evaluation was completed to ascertain what is necessary to bring the entire campus in to compliance with District of Columbia and National Fire Protection Association (NFPA) codes. The overall cost estimate totals $66,525,000, not including removal of hazardous waste materials. This study was carefully monitored, reviewed and found acceptable for use in developing cost estimates to bring all buildings up to code identified and necessary for mental health service delivery.

Based on the District's Preliminary Plan for use of the East-side campus only, we are beginning the process of developing program of requirements to determine all work that must be accomplished for the transfer to the District government. The D.C. proposal does not identify facilities on the West-side of Martin Luther King, Jr., Avenue for use by the mental health system. The cost budget to comply with this provision of the law will be completed in the coming months for submission in the Fiscal Year 1988 budget request. The law requires the Secretary to make repairs and renovations to the physical plant and facility support system to be utilized by the District's mental health program. However, according to Public Law 98-621 the final D.C. plan will not be submitted to Congress until October 1, 1986. Should any major changes be made in the plan we will be required to restudy both the hospital audit and the D.C. Implementation Plan.

We believe the estimate in excess of $40 million derives from a separate study commissioned by the District government and represents their estimate for improvements to the East-side campus only. The purpose and scope of this study differs from ours in several significant areas:

- The District study is broader. The stated purpose in the report is to "determine the physical state of the buildings as well as establish a cost estimate for renovation work to create modernized facilities to meet present day standards for mental health treatment." P.L. 98-621, Section 4(f)(1) requires the Secretary to "contract for a ... physical plant audit of all existing facilities at the hospital to be

BEST COPY AVAILABLE

completed by January 1, 1986. ... The physical plant audit shall recognize any relevant national and District codes and estimate the useful life of existing facility support systems."

- The cost estimate model was based on actual renovation costs for the Continuous Treatment Complex (CT) at the hospital. In general, the proposed renovation work is to be comparable to level of finishes of the CT complex, including general exterior repairs, painting, and cleaning. Costs include a 10.5% project management and design fee.
- The report contains a section on a new steam plant. We have been proceeding with major repairs to the steam plant, which will provide for effective steam generation for several years in the future.
- Each building is identified in terms of proposed use, cost of renovations, if any, or in some cases demolition.
- Site work utilities are not included.

After the Department's initial estimates are developed, we will enter into discussions with District officials.

DEATH OF SEH PATIENT

Mr. Natcher. Last January there was a tragic death at the hospital involving a patient named Emery Lee who had been placed in isolation. Tell us what caused this death and what actions have been taken to prevent future injuries?

Mr. Trachtenberg. We are still awaiting the written report of the D.C. Medical Examiner concerning the death of Mr. Emory Lee, even though District officials held a press conference on March 14, 1986, stating the death was due to natural causes complicated by a heart problem, mental retardation, Down's Syndrome, and obesity. Until that report is received it would be too early to make any informed judgments concerning the circumstances of the death.

However, Saint Elizabeths Hospital has taken several actions to prevent or better deal with any similar future incidents. In addition to conducting its own internal review of exactly what happened, Saint Elizabeths Hospital staff have cooperated and are cooperating with an investigation by the District of Columbia Police Department, with a review by the Health Care Financing Administration, and with a review of the incident being conducted by the staff of the House Committee of the District of Columbia. Special attention is being given to this last review by Delegate Walter E. Fauntroy and the Subcommittee on Fiscal Affairs and Health, which he chairs.

In addition to these reviews, Saint Elizabeths has taken further steps to assure that at all times there is a sufficient number of appropriately trained staff providing inpatient services throughout the hospital, with special attention to the staffing in the area where Mr. Lee died. Some registered nurses who work in that division of the hospital and who previously have been assigned to outpatient duties only are working on inpatient shifts as well. Clinical staff on those wards have also been instructed to carefully monitor patients during times when the weather becomes warm and to immediately notify the engineering staff if it is necessary for the heat to be cut back or turned off. Engineering staff are also assisting with monitoring the heat in buildings to assure that safe levels are maintained.

AUTHORIZING LEGISLATION

Mr. Natcher. The budget request for the alcohol and drug abuse research programs is not currently authorized. What is the status of legislation to reauthorize these programs.

Mr. Trachtenberg. As you know, the authority to conduct basic research for both NIAAA and NIDA is contained in Title V of the PHS Act. The authorities establishing NIAAA (Section 502, PHS Act) and NIDA (Section 503, PHS Act) both incorporate by reference Section 301 of the Public Health Service Act, a general research authority for the Public Health Service which does not expire. This authority is available for use by these Institutes.

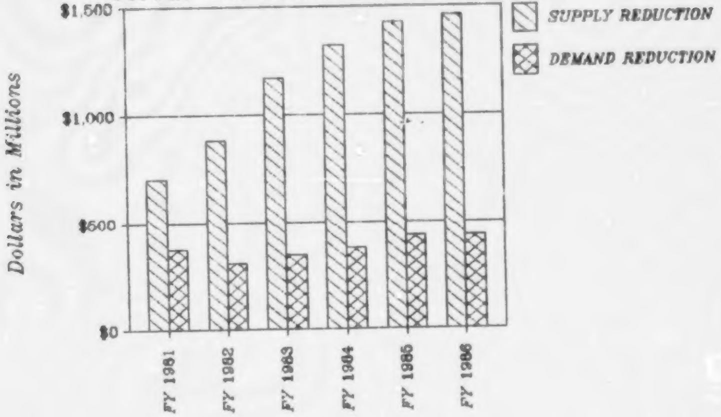
In addition to Section 301, Title V contains additional authorizations of appropriation for NIAAA (Section 513, PHS Act) and NIDA (Section 517, PHS Act). These authorities expire September 30, 1986. However, both the House Subcommittee on Health and the Environment and the Senate Subcommittee on Children, Family, Drugs, and Alcoholism have held hearings to re-authorize these specific authorizations of appropriations. As of this writing, bills have not yet been introduced in the House and Senate but are expected in the immediate future. For this reason the 1987 Congressional Justification cited Section 301 as the available authorizing legislation.

DEMAND REDUCTION

Mr. Natcher. Earlier this year your staff submitted two charts to the Committee on Federal drug activities. We will insert these in the record at this point. The first chart displays federal spending over the last six years. This shows an increase of almost 100% in resources for drug interdiction programs. The second chart shows the availability of the major classes of drugs during this period as virtually unchanged. What conclusion would you recommend that this Committee draw from this data?

FEDERAL DRUG ABUSE BUDGET

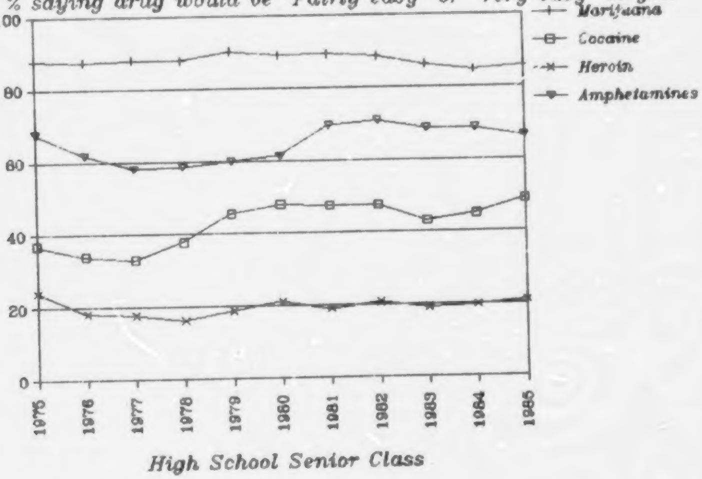
SUPPLY AND DEMAND REDUCTION ACTIVITIES



(SOURCE: OMB/DRUG ABUSE POLICY OFFICE)

TRENDS IN REPORTED AVAILABILITY

% saying drug would be "Fairly easy" or "Very easy" to get.



Mr. Trachtenberg. Mr. Chairman, I would hope that the Committee would not conclude that the Federal interdiction efforts have not been important in holding the line on the problem. I believe such a conclusion could do great harm to our efforts to combat drug abuse in this country. What one must ask when reviewing data such as these is what would the levels of availability of drugs be without these increased interdiction efforts.

We are now seeing evidence that the availability and use of certain illicit drugs is increasing. For example, the most recent High School Senior Survey indicates that the five year decline in drug use by high school students appears to have stalled in 1985. The use of marijuana is no longer declining, and the use of cocaine is increasing. The latest survey indicates that 4.9 percent of high school students use marijuana daily and about 6.7 percent use cocaine at least once a month. While these are clearly alarming levels of use of these substances, imagine what the levels might be if marijuana and cocaine were as readily available as cigarettes. Almost 20 percent of high school students smoke cigarettes daily, and over 30 percent have smoked in the last month. Without the efforts of the Federal interdiction programs, there is no reason to believe the levels of use of marijuana and cocaine would not approach these higher levels.

So long as a demand for drugs exists and there is money to be made in dealing drugs, there will be people who will take what ever chances are necessary to profit from it. In the long run, we can only solve the problem of drug abuse by eliminating the demand for drugs by the American people. We clearly need a strong program of research on drug abuse to develop more effective prevention and treatment programs. But in the short run, we must maintain a strong interdiction effort lest we be overwhelmed by a flood of drugs into the country.

DRUG TESTING

Mr. Natcher. Dr. Shuster, the President's Commission on Organized Crime has just issued a report calling for drug use tests for all workers. What is your reaction to this recommendation?

Dr. Schuster. The recommendation, as I understand it, was for Federal agencies to develop a clear policy statement indicating that substance abuse by Federal employees is unacceptable. This is a position we could clearly support. The President's Commission further recommended that these Federal policies should include provisions for drug testing programs where suitable. The issue of suitability or appropriateness here is critical. Clearly within the Federal Government there are critical skill occupations of a safety or security nature where employee drug testing may be appropriate. The Department of Defense has already implemented such a policy for civilian employees.

It is unlikely that the massive screening of all Federal workers could be justified as being appropriate or suitable. However, we support the development of drug policies within the Federal Government, as we have with private industry, that are fair and equitable and achieve a balance between the rights of the employer and the rights of the employee. Urine screening can be an effective tool in the early identification of employees with drug problems and should be considered a useful technique within an overall program of treatment, prevention, and education.

Mr. Natcher. What role does the National Institute on Drug Abuse have in the development of accurate drug tests or in setting standards for drug testing?

Dr. Schuster. NIDA's role is primarily one of providing technical assistance to State, local and Federal officials and private industry in the development of standards for drug testing.

NIDA has no regulatory authority in this area. However, because of our expertise in the drug abuse fields and, in particular, in the research on which drug testing technologies are based, we have acted to bring together Federal agencies who do have regulatory authority such as the Food and Drug Administration, the Health Care Financing Administration, and the Bureau of Standards as well as professional societies and individuals with the appropriate expertise and authority, to explore the issues involved and to make recommendations concerning the establishment of guidelines, standards, and laboratory certification requirements. For example, NIDA has worked with the Departments of Transportation, Defense, and Justice in the development of research data on drug effects on performance and on the establishment of drug screening programs. We provided assistance to the Department of Defense and the White House in organizing two White House meetings with DOD personnel and outside forensic experts to assist in the development of a large and ambitious drug screening programs in DOD which is credited with causing significant reductions in the use of illicit drugs in the military.

As part of our basic research effort, we support the development of improved assays for the detection of drugs in body fluids and the development of techniques and procedures for improved accuracy in drug analysis.

AIDS RESEARCH

Mr. Natcher. How much money is currently set aside in each of the Institute's budget requests for AIDS? What type of projects are currently under way?

Mr. Trachtenberg. The National Institute of Mental Health (NIMH) has solicited and will be funding grants in the areas of psychoimmunology and neuropsychology of AIDS, as well as funding psychosocial studies of AIDS. Additional areas of research emphasis include studies examining neuropsychologic and psychoimmunologic aspects of high-risk behavior and interventions for those behaviors, studies of minority populations at high risk for AIDS, and studies assessing interventions to reduce psychiatric and psychologic symptoms in AIDS patients. NIMH and the National Institute on Drug Abuse (NIDA) will be jointly funding several research centers on mental health and substance abuse aspects of AIDS, which will be established at currently functioning research/treatment centers for AIDS. During fiscal year 1985 NIMH funded 17 AIDS research projects totaling $1.8 million. During fiscal year 1986 it is anticipated that NIMH will fund 31 projects totaling $3.7 million and will fund 39 projects in fiscal year 1987 totaling $5 million for AIDS research.

In addition to its research function, NIMH will fund numerous efforts in both years which address the need for education and knowledge transfer efforts focused on the psychosocial and neuropsychologic aspects of AIDS. These efforts include publications for health care professionals on the psychosocial needs of AIDS patients and their health care providers; monographs on the psychoimmunology and neuropsychology of AIDS; publications on the psychosocial and neuropsychologic aspects of pediatric AIDS; workshops on neuroscience and neuropsychologic aspects of AIDS, the impact of HTLV-III screening, neuropsychologic research methodology for AIDS; and education efforts to increase the awareness of psychosocial and neuropsychologic aspects of AIDS among health care personnel. It is anticipated that $1.4 million will be spent in fiscal year 1986 for these AIDS activities and that $1.1 million will be spent for them in fiscal year 1987.

NIDA has solicited research applications and will considerably expand its research funding for studies of the epidemiology of HTLV-III infection and/or AIDS among IV drug using samples emphasizing comparisons between high and low prevalence areas; studies of the social networks of drug abusers as models of infectious disease communication vectors; studies of HTLV-III infection among pregnant drug abusers and their offspring; studies of drug using patterns among prostitutes; studies of drug abuse cofactors for AIDS and HTLV-III infection; studies of the variant clinical courses of HTLV-III infection and AIDS among drug abusers compared to other risk groups for AIDS. NIDA will jointly sponsor with NIMH research centers focused on mental health and substance abuse aspects of AIDS. During fiscal year 1985, NIDA funded 3 grants totaling $560,000, while in fiscal year 1986 it is anticipated that NIDA will fund 10 grants and contracts totaling $5.3 million and will fund 10 grants and contracts in fiscal year 1987 totaling $5.8 million.

In addition to its research efforts, NIDA will provide HTLV-III screening for the criminal justice system, drug treatment and therapeutic community programs; provide training and technical assistance activities to health care providers including publications and workshops; provide information relevant to preventing the spread of AIDS among IV drug users to drug abusers and their families; and participate in joint Public Health Service meetings on drug abuse cofactors for AIDS. During fiscal year 1986 and fiscal year 1987 $1.8 million will be funded for these activities.

It should be noted that all fiscal year 1986 figures reflect Gramm-Rudman sequestration, while the fiscal year 1987 figures do not.

DRUG ABUSE DATA COLLECTION

Mr. Natcher. Several Members have approached the committee expressing their concern about our ability to monitor drug abuse in this country. This concern focuses on funding for the DAWN and CODAP data networks. Describe these systems for the Committee if you will and tell us how much money is expected to be spent on each in 1985, 1986 and 1987.

Mr. Trachtenberg. The Drug Abuse Warning Network (DAWN) was developed by the Drug Enforcement Administration (DEA) in 1972. NIDA assumed joint responsibility for DAWN in 1974 and in 1981 a decision was made to turn complete management responsibility for DAWN over to NIDA.

DAWN was conceived as an early warning system, designed to identify, in the shortest possible time, drug abuse epidemics so that effective action could be taken at the Federal, State and local levels. Data pertaining to drug abuse episodes are collected from a non-random sample of emergency rooms and medical examiners in 27 selected metropolitan areas through the United States.

DAWN represents the only source of current, ongoing, data on harmful consequences of drug use. The data allows us to monitor changing trends in drug use as well as changes in the age, sex, and race of people suffering from the harmful effects of drugs. It is important to note that DAWN does not directly measure the prevalence of drug use. What DAWN measures are the consequences associated with drug use.

A number of efforts are underway to improve DAWN. One of the most important of these involves improving the design, selection, and recruitment of a new DAWN sample that would be representative of specific metropolitan areas and the nation as a whole. The advantage of drawing a representative sample is that NIDA would then be able to make national estimates of the number of cases associated with drugs in the United States as well as each of the metropolitan areas included in the DAWN system.

The major costs involved with DAWN are contract costs for data collection. In FY 1985, $1,250,000 was spent on the DAWN contract. A new contract was recently awarded in open competition which fixed the annual costs at $1,250,000. This will, therefore, be the amount spend in FY 1986 and FY 1987. The remainder of the cost associated with DAWN involve computer processing charges, which run about $120,000 per year.

Prior to FY 1982, The Client Oriented Data Acquisition Process (CODAP) was a required reporting process for all drug abuse treatment and rehabilitation units receiving Federal funds for the provision of drug abuse treatment and rehabilitation services. The system, started in 1973, represented approximately 50 to 60 percent of all treatment units in the nation. In 1981, when all States and territories were using CODAP as the basic reporting system, approximately 2,200 clinics reported to CODAP on more than 250,000 admissions annually.

With the implementation of the Alcohol, Drug Abuse and Mental Health (ADM) Block Grant in FY 1982, participation in CODAP became voluntary and reporting has varied. In 1985, approximately 15 States still reported treatment admission data to NIDA. Generally, as States have developed their own data systems or found costs increasing, they have stopped reporting treatment data to NIDA.

When CODAP was a required reporting system, the data were submitted monthly and provided NIDA with timely information on the numbers of characteristics of people seeking treatment for drug abuse. With only 15 States reporting, we no longer are able to obtain reliable information on nationwide trends in the drug abuse treatment population. However, we still process CODAP because of the value of the information that can be obtain from it. The cost of processing the CODAP data is approximately $50,000 per year.

Because of the value of the data, plans have been initiated to modify the system to make it more attractive to and compatible with the States. A contract to implement some design changes in the CODAP system has been awarded at a cost of $125,000 in FY 1986 and FY 1987. Consideration is also being given to a study to determine the degree to which private treatment programs would be willing to provide treatment data to NIDA for research purposes on a time limited basis.

NIAAA INTRAMURAL PROGRAM

Mr. Natcher. Mr. Archer, tell us how much money is included in your budget for the intramural program and also tell us what initiatives are anticipated in this program?

Mr. Archer. The President's Budget Request or FY 1987 includes $9,903,000 for the support of intramural research. Although this reflects an overall programmatic decrease, the Institute is eager to enhance its work in particular areas that are presenting some very exciting opportunities. This includes the application of molecular genetics techniques to the development of alcoholism and alcohol-derived disease states, the development and testing of improved pharmacologic tools for the treatment of alcoholism, and the use of sophisticated nuclear magnetic resonance (NMR) technologies for determining the mechanisms producing tolerance and physical dependence and for developing novel approaches for the diagnosis and evaluation of alcohol-induced organ damage through noninvasive (nonsurgical) procedures. The application by the intramural program of these sophisticated research tools to the clinical problems of alcohol abuse will allow substantial progress in understanding the role of the genetic factors that influence the development, or the inhibition of alcoholism, as well as for the development of improved procedures for the earlier detection of alcohol-pathologic effects and for monitoring the disease process and the impact of particular therapeutic procedures.

MAGNETIC RESONANCE ACTIVITIES

Mr. Natcher. How much money was included in your original FY 1986 budget request for magnetic resonance activities and how much are you currently budgeting for this purpose in FY 1986?

Mr. Trachtenberg. The original FY 1986 President's Budget Request provided for the support of ongoing research in the intramural program, which did not then include activities in the area of magnetic resonance. The amount appropriated, after sequestering, will allow developments in the NMR area to be incorporated into the intramural research activities at the level of $500,000. This will provide for the purchase of a high resolution spectrometer that will be placed in the NIH Central NMR Facility as well as for the NIAAA's initial share of costs for the overall development of the facility. Contribution towards the development and operation of centralized facilities for NMR research at the NIH will allow the alcohol research program to have access to high resolution spectrometry as well as several instruments at the facility that are capable of imaging and of spectroscopic analyses from in vivo, living animals and humans.

Mr. Natcher. How much money is included in your FY 1987 budget for magnetic resonance activities?

Mr. Trachtenberg. The FY 1987 President's Budget Request provides $250,000 for the intramural support of magnetic resonance activities. This will allow for the second installment of the NIAAA contribution to the NIH Centralized NMR Facility, projected at $75,000, and operating funds for selected experimental protocols. In view of the substantial gains that are possible by the application of NMR technology to the clinical problems of alcohol abuse, this area is considered a high priority by the Institute and will be supported despite the need for an overall intramural programmatic decrease reflected in the FY 1987 Budget. This will be achieved in FY 1987 by the refocusing of a number of ongoing intramural projects in relevant scientific areas, so as to begin to exploit the availability of NMR technology for spectroscopic analyses and imaging studies of alcohol-induced organ damage and of cellular changes associated with the addictive process.

SCHIZOPHRENIA INITIATIVE

Mr. Natcher. In December of 1984, Secretary Heckler announced a $5 million effort to support 4 centers studying more effective methods of treating schizophrenia. What is the status of this initiative and how much has been spent on these centers to date?

Mr. Trachtenberg. In FY 1984 four centers were funded to begin this multicenter study of pharmacologic and psychosocial treatment in schizophrenia that Secretary Heckler announced in December 1984. The centers are Cornell University Payne Whitney Clinic in New York City; Hillside Hospital Division of Long Island Jewish Hospital in Glen Oaks, New York; Eastern Pennsylvania Psychiatric Institute at Medical College of Pennsylvania in Philadelphia, and San Francisco General Hospital at the University of California-San Francisco. A fifth center at Emory University-Grady Memorial Hospital, Atlanta, was added in 1985. To date, $2.5 million in grant funds has been awarded.

All the centers are following identical study procedures developed by the NIMH in cooperation with the group. Briefly, the goals of the study are 1) to maximize the benefits of drug treatment for schizophrenia at the same time that the risk of tardive dyskinesia is reduced by using reduced doses of medication and 2) to reduce the rate of relapse and improve social functioning and participation in family life by teaching families how to manage problems associated with schizophrenia. Patients and families participate in a two year treatment program. Patients receive either standard dose, low dose or targeted medication (receiving medication only when symptoms appear). All patients and their families also receive education regarding the illness and participate in supportive multiple-family groups or active problem solving sessions conducted in the home.

Following an initial training period for staff the first patients entered the study in May 1985. As of March 1986, 83 patients have entered the study. Funding will continue through FY 1989 and initial results of the study will be available in FY 1990.

Mr. Natcher. Are all 4 of the schizophrenia centers meeting the standards which you have set for them.

Mr. Trachtenberg. As we have indicated, five rather than four centers have been funded. We are very pleased with the productivity of the group. They are working together, using the same research methods and studying the same treatments following uniform procedures developed by staff at the National Institute of Mental Health. To date approximately 100 patients have entered the treatment study and the procedures work well at all the sites.

RESEARCH TRAINEES

Mr. Natcher. Mr. Trachtenberg, the budget request for research training is down from $21 million in 1985 to $18.5 million in 1986. Tell us how many trainees will be supported in each year and tell us why you are proposing a decrease?

Mr. Trachtenberg. In 1986 ADAMHA is requesting a total of 959 research trainees; in 1987, the request is for 882 trainees. Given the current budget realities, it was felt that a lower level of federally supported trainees is now adequate to maintain our research program in the future. Research training today takes place to a larger degree in a number of other settings, i.e., research centers, intramural programs, and even in project grants. Our continual influx of excellent grant applications attests to the validity of this approach.

RESEARCH TRAINING STIPENDS

Mr. Natcher. In 1985, Congress increased funding for research training by approximately 20 percent. This increase was put almost entirely into increases in stipends. That was your decision as to how to use the increase. We have heard, however, that these stipends had already been increased by the host institutions and that this increase had no practical effect. Is this true?

Mr. Trachtenberg. The stipend increases in 1985 for research training were made throughout the Public Health Service for research trainees and fellows. NIMH agreed with NIH that inflation had eroded previous levels so that they were no longer attractive to the better students, particularly at the postdoctoral level. We have no information that the training institutions had supplemented these stipends to any great extent, and most institutions did not have the funds to do so. We have, to the contrary, noted the effect of the larger stipends in the greater interest in research training by postdoctoral candidates, particularly physicians. Increasing the number of physician clinical researchers has been a high priority for some time.

BLOCK GRANTS

Mr. Natcher. Would an increase in Federal funds for the Block Grant be used by the States to expand services or would it merely substitute Federal funds for State funds without expanding services?

Mr. Trachtenberg. Both the current block grant statute and the statutes which authorized the Federal categorical programs of assistance which preceded it, contained prohibitions requiring that Federal funds "supplement, not supplant" State funds for the provision of prevention and treatment services. Simply put, this provision prohibits States from substituting Federal funds for existing State expenditures in these programs. Federal funds must be supplemental to those funds a State is already spending. The

States are very familiar with the "supplantation restriction," and we have no reason to believe that the States would violate the law by attempting to substitute Federal [illegible] for State funds.

NIAAA DEMONSTRATION AUTHORITY

Mr. Conte. The report indicates progress and results in many of the Institute's demonstration projects on 3rd party coverage for alcoholism treatment. What are the Institute's continuing needs in demonstration authority in this and other areas?

Mr. Trachtenberg. The NIAAA requires continuing funding at sufficient levels to undertake the proposed research described in the report. Continuing study of prospective payment mechanisms and levels for alcoholism treatment services are needed. In addition, further study and analysis related to Medicare, Medicaid and other third party coverage and benefit limits should be undertaken.

NIAAA MONITORING STUDY

Mr. Conte. What process would you envision to develop and implement a large scale outcome monitoring study? Would you contemplate some sort of cooperative agreement with private sector treatment programs?

Mr. Trachtenberg. Such studies are very expensive, involve a relatively long time frame (minimally 5 years) for completion, and require staff highly trained for this type of research. A collaborative project covering several types of settings and treatment modalities would be desirable, and would need to be done in collaboration with either public or private sector treatment programs. Institute staff expertise, as well as outside expertise would be utilized in the design, implementation, and analyses of such a large scale project.

The NIAAA is pleased to report that it has recently funded a large scale outcome study comparing inpatient and outpatient settings among problem drinkers in the work force. The NIAAA, in cooperation with a private foundation, is sharing the costs of this project. The purpose of the study, which employs a randomized design to assign subjects into treatments, is to compare three different approaches to the treatment of problem drinkers in the work-site identified by labor or management.

TASK FORCE ON REIMBURSEMENT

Mr. Conte. The report mentioned a task force on reimbursement on which is represented senior staff of all 3 ADAMHA Institutes. Can you tell the Committee what the objectives of this task force are, what progress there has been to date, and whether it is expected that the task force will have an effect on private coverage and on Medicare?

Mr. Trachtenberg. The objective of the task force is to assist in the development of Agency wide positions on ADM financing and coverage policy issues. This task force should help us integrate the financing and coverage policy implications of research findings from each of the three Institutes.

To date, the task force has been successful in launching a major study to address industry concerns that were raised about Medicare's DRG payment system for alcohol and drug services. Their work is being carefully coordinated with ASPE and HCFA and is expected to have a direct impact in resolving issues of concern to the alcohol & drug services community.

The task force is expected to continue to provide data and analysis that will be valuable to decision makers considering private coverage as well as Medicare.

NIAAA RESEARCH BALANCE

Mr. Conte. Is it reasonable to expect the NIAAA to manage a program of research which effects a balance between basic biological research and patient placement/treatment assessment type research?

Mr. Trachtenberg. It is quite reasonable to expect the NIAAA to balance and integrate biological research and patient placement/treatment assessment type research. Both are equally important to reaching a full understanding of the disease of alcoholism. An understanding of the underlying biological substrata inherent in alcoholism must be tempered with how such characteristics and predispositions can be best treated therapeutically, in applied settings. It is the position of NIAAA to utilize findings from biological research and seek methods to implement and integrate such findings into the delivery of treatment. For example, the use of biologically-oriented screening instruments has become a part of the information used by clinicians in making diagnoses as to the severity or degree of alcohol dependence. Accurately assessing the patient's degree of dependence, as well as concomitant medical ailments, is an essential ingredient in determining the best treatment for that particular client.

NIAAA RESEARCH CENTERS

Mr. Conte. I understand that NIAAA is competing 5 of its 9 NIAAA research centers this year. Has that competition begun, and can you indicate what priorities you are looking for, and how these priorities have changed from the topics covered by the current research centers?

Mr. Trachenberg. The NIAAA held a competition in FY 1985 to evaluate a total of 9 applications for Centers. This included 5 applications requesting renewal support for existing Centers and 4 applications to establish new Centers. Based on the recommendations of the scientific peer review group and the National Advisory Council, the 5 recompeting Centers were approved and funded earlier this fiscal year for an additional period of support. No applications for new Centers were recommended for funding. Thus, the research being conducted at the Centers continues to build upon their past accomplishments and represents state of the art science in the alcoholism field.

The next competition for Centers will be for FY 1988 support, when support for several of the existing Centers expires. The competition has been announced to the scientific community and applications for grant renewals, as well as applications to establish new Centers, are due in January 1987. The NIAAA is encouraging applications dealing with areas of continuing and increasing interest such as the genetics of alcoholism, the assessment of treatment and matching clients to treatments, children of alcoholics, effects of alcohol on the immune system and the risk for infection, and research in the neurosciences. Of course, NIAAA will continue to support the highest quality research across a broad range of topics.

TREATMENT FOR COCAINE ADDICTION

Mr. Conte. I understand that some pharmaceutical treatments for cocaine addiction have recently begun to be employed, including anti-depressants as part of the therapy. Is this a promising treatment for cocaine addiction, which has been a field in search of a treatment for the past several years?

Mr. Trachtenberg. Pharamacotherapy is a relatively new approach in the treatment of cocaine addiction. While more research will have to be done before definite conclusions can be drawn, the use of anti-depressants in the treatment of cocaine addiction does seem promising, at least for some cocaine users.

In a pilot study, the tricyclic antidepressant, desipramine, was used in concert with individual psychotherapy. After three weeks of treatment, the participants' craving for cocaine was significantly reduced. Among a group of patients for whom psychotherapy had proven ineffective, a four week treatment regimen with desipramine resulted in 100 percent abstinence. Again, this was a pilot project; conclusive findings will require expanded studies. Desipramine has also appeared effective in treating cocaine abusers with and without diagnoses of major depression disorder.

Other pharmacotherapies, such as imipramine, l-tyrosine and tryptophan have been used to treat the severe depression that follows cocaine withdrawal, although to date no rigorous, controlled trials have been done to verify these effects. Lithium has been shown useful in treating a limited number of cocaine abusers by blocking the cocaine induced euphoria and reducing several manifestations of a concurrent cyclothymic disorder. The prescribed medication, methylphenidate, has shown limited use in ameliorating pre-existing or resultant behavioral and affective disturbances associated with heavy cocaine use.

Research on the development of new treatments for cocaine abuse is one of NIDA's highest priorities. Several studies are now underway, and new studies are being planned.

NIMH REORGANIZATION

Mr. Conte. From time to time, we have heard about the reorganization underway at NIMH, and it seems that for the most part, you have been able to calm the concerns of most individuals and groups that felt threatened by the reorganization. Lately, we have been hearing a little bit from the social workers. Can you describe what their concerns are, and how you feel the reorganization of NIMH will affect their concerns.

Mr. Trachtenberg. A number of social workers have been concerned about the impact of the reorganization on the Institute's ability to continue to emphasize the importance of the social work profession in the delivery of mental health services. Particular concern has been expressed regarding the consolidation of all clinical training programs within another organizational unit. Within NIMH's continuing clinical training activities there continues to be emphasis on social work education activities. In addition, social workers occupy a number of key leadership positions within the new Institute organization.

MASSACHUSETTS 1st CONGRESSIONAL DISTRICT AWARDS

Mr. Conte. For the record, will you provide a list of grants and awards from ADAMHA in the 1st Congressional District of Massachusetts?

Mr. Trachtenberg. The following table lists the current ADAMHA awards in the 1st Congressional District of Massachusetts:

Grant Number	P.I. Name, Institution and Title of Project	Dollars Awarded
2 K02 MH00321-06	WADE, GEORGE N UNIVERSITY OF MASS AMHERST HORMONE ACTIONS ON BEHAVIORS	$60,288
5 K05 MH00332-05	CLIFTON, RACHEL K UNIVERSITY OF MASS AMHERST AUDITORY COMPETENCE AND LEARNING IN HUMAN INFANTS	50,222
1 K05 MH00363-01A2	EPSTEIN, SEYMOUR UNIVERSITY OF MASS AMHERST AGGREGATION IN PERSONALITY RESEARCH	58,491
5 R01 MH01293-26	EPSTEIN, SEYMOUR UNIVERSITY OF MASS AMHERST THE MEASUREMENT OF DRIVE AND CONFLICT	79,580
5 T32 MH16745-05	ROYER, JAMES M UNIVERSITY OF MASS AMHERST APPLIED AND BASIC COGNITION	58,811
5 T32 MH17120-03	TESSLER, RICHARD C UNIVERSITY OF MASS AMHERST RESEARCH TRAINING IN MENTAL HEALTH SERVICES	86,251
5 T01 MH17541-03	TURNER, CASTELLANO B UNIVERSITY OF MASS AMHERST PSYCHOLOGICAL TRNG FOR MINORITY/DISADVANTAGED STUDENTS	35,307
5 T01 MH17979-03	HARMATZ, MORTON G UNIVERSITY OF MASS AMHERST CLINICAL PSYCHOLOGY TRAINING	48,862
2 R01 MH32131-08	ANDERSON, DANIEL UNIVERSITY OF MASS AMHERST PRESCHOOL CHILDREN'S HOME TELEVISION VIEWING	142,628

1 R01 MH39960-01	FISHER, DONALD L UNIVERSITY OF MASS AMHERST A SINGLE PROCESS THEORY OF VISUAL SEARCH	27,528
1 R01 MH40029-01	MYERS, JEROME L UNIVERSITY OF MASS AMHERST COMPREHENSION AND MEMORY OF TEXT	50,844
1 R01 MH40131-01	AVERILL, JAMES R UNIVERSITY OF MASS AMHERST SOCIAL BASES OF EMOTIONAL BEHAVIOR	54,314
1 R03 MH40681-01A1	TRONICK, EDWARD C UNIVERSITY OF MASS AMHERST INFANT COPING STRATEGIES WITH AN INTERPERSONAL STRESS	22,200
	TOTAL	$775,326

SAINT ELIZABETHS HOSPITAL

Mr. Conte. Dr. Frazier, Federal payments to the hospital are set to continue until Fiscal Year 1990, is it correct that those funds will go to the District through our D.C. Subcommittee, and that this will be your last appearance before the Subcommittee requesting funds for the Hospital?

Dr. Frazier. It is correct that Federal payments to the hospital and the D.C. Mental Health System will continue through Fiscal Year 1991. Although the hospital will no longer be an entity of the Federal Government the transfer of the hospital management to the District of Columbia will require a budget request through mechanism of both the D.C. Appropriation Subcommittee and this committee during the financial transition period, which ends on October 1, 1991.

There are two major categories related to the hospital which will be included in the agency's budget request:

- the Federal Government will provide decreasing financial support as a part of the ten year plan in the following amounts:

  $30 million for Fiscal Year 1988
  $24 million for Fiscal Year 1989
  $18 million for Fiscal Year 1990
  $12 million for Fiscal Year 1991

- o second, under Public Law 98-621 the Department is responsible for appropriations to make repairs and renovations to the physical plant and facilities support system of the hospital to be utilized by the District to meet code requirements and standards.

In addition, transfer legislation provides for a special subsidy to the District government as follows:

$25 million	for Fiscal Year 1986
$35 million	for Fiscal Year 1987
$30 million	for Fiscal Year 1988
$20 million	for Fiscal Year 1989
$15 million	for Fiscal Year 1990
$10 million	for Fiscal Year 1991

Mr. Conte. How much will the FY 1986 appropriation to the Hospital be reduced under Gramm-Rudman-Hollings?

Dr. Frazier. The Federal appropriation is reduced by $1,879,000; resulting in spending authority of $41,817,000. In addition, revenues from other sources, including the District of Columbia Government, are sequestered by reduction of spending authority of $1,842,000. Total reduction in spending authority for FY 1986 is $3,721,000.

Mr. Conte. The timetable that was agreed on for transferring responsibility of the hospital to the District had a set series of Federal and District payments. Has the 4.3 percent reduction caused any problems with that timetable?

Dr. Frazier. The fiscal year 1986 sequestration did not affect that timetable. The general impact of sequestration will be to reduce staff services, including direct clinical care and patient support services. However, programs will not be curtailed nor will this cause any delay in the timetable for transfer of responsibility to the District of Columbia specified in Public Law 98-621. Supervision of supply and equipment purchases will represent deferral of necessary items to Fiscal Year 1987. Overall stringent austerity measures will be applied across the board which will be extraordinarily difficult, but the hospital will accomplish its basic treatment mission.

Mr. Conte. Your statement says you'll be making up for those Gramm-Rudman reductions in part by increased reimbursements in areas not subject to Gramm-Rudman sequestration. What areas are those and how much will you be able to make up here?

Dr. Frazier. Due to an audit and changes for the Hospital's cost accounting methods, increased reimbursements from Medicare of approximately $500,000 can be achieved in FY 1986. The primary source of the $500,000 is the recognition and application of depreciation in computing Medicare billing rates. The audit, conducted by an independent accounting firm in accordance with generally accepted accounting principles (GAAP), resulted in the issuance of an unqualified opinion that the financial statements fairly represent the financial position of the hospital and that no material weaknesses were identified in the internal control practices at the hospital. Medicare payments are subject to Gramm-Rudman but only to a level of 1 percent. Thus, total reimbursements from Medicare will exceed budget projections by $500,000.

Mr. Conte. As you know, Doctor, every year we have one of two incidents out at the Hospital that attract a lot of media attention. Recently we were all distressed to hear that a patient had died at the Hospital after being placed in a seclusion room. Can you tell us about this incident in particular, and what the Hospital's policy on seclusion is in general?

Dr. Frazier. As of March 20th the Hospital is still awaiting the formal report from the District of Columbia medical examiner's office to provide the cause of death for Emery Lee. That office has announced that Mr. Lee's death was from natural causes.

In addition to conducting its own internal review of exactly what happened, Saint Elizabeths Hospital staff have cooperated and are cooperating with an investigation by the District of Columbia Police Department, with a review of the incident being conducted by the staff of the House Committee of the District of Columbia. Special attention is being given to this last review by Delegate Walter E. Fauntroy and the Sub-committee on Fiscal Affairs and Health which he chairs.

Although Saint Elizabeths Hospital has not yet received a written report from HCFA on its findings, the HCFA site team reported at the exit conference that they had found no improper staff actions. The Hospital's Utilization Review Committee is examining the appropriateness of the admission of Mr. Lee, the environment in which he was treated, the supervision and training of staff involved, the seclusion policies, and the medical care received. That committee will shortly be presenting its findings and recommendations to be Hospital Superintendent. The Superintendent will then release to the public a statement on his conclusion.

In addition to these reviews, Saint Elizabeths has taken further steps to assure that at all times there is a sufficient number of appropriately trained staff providing inpatient services throughout the Hospital, with special attention to the staffing in the area where Mr. Lee died. Some registered nurses who work in that division of the Hospital and who previously have been assigned to outpatient duties only are working on inpatient shifts as well. Clinical staff on those wards have also been instructed to carefully monitor patients during times when the weather becomes warm and to immediately notify Engineering if it is necessary for the heat to be cut back or turned off. Engineering staff are also assisting with monitoring the heat in buildings to assure that safe levels are maintained.

The Hospital's policy on "Seclusion and Restraint" is quite detailed, specific, and is frequently reviewed. The policy views seclusion and restraint as extreme measures to be used only when necessary for the safety of the patient or other patient and for specific therapeutic reasons. Seclusion and/or restraint can only be used when other measures have been attempted or when these are the least restrictive measures that can control the patient's behavior. Seclusion and restraint can only be used on a physician's order which is time limited (not to exceed 24 hours) and must specify the conditions of seclusion and/or restraint and the reasons for its necessity. After each 24 hour period if there is demonstrated need for continued seclusion, a new physician order must be written. A progress note must document alternative measures that have been considered. Patients must be given periodic trials in the ward environment to assess the need for continued seclusion. Seclusion use is reviewed by each division's medical director or designee on a daily basis.

Mr. Conte. If part of the problem is the aggressive behavior of patients, what does that signal for the District's plan to move a number of patients into a community setting?

Dr. Frazier. The District's plan to move a number of patients into a community setting does not anticipate the move of any patient with uncontrolled aggressive behavior. Patients to be moved must meet specific criteria which will be reviewed by individuals other than the treatment team. The District's plan retains the use of intensive inpatient treatment for patients with uncontrolled aggressive behavior.

Mr. Conte. As you move ahead into this transfer year, are you facing any difficulties in terms of reassigning personnel from the Hospital to the District's community mental health centers?

Dr. Frazier. At present, there are several areas in which there are open questions to be resolved prior to assignment of staff presently providing outpatient services to SEH patients to the District's mental health centers along with the patients they serve. These include repairs and renovations of the District's facilities, providing for necessary liability coverage for transferred staff, providing for necessary support services (for example, laboratory services) for transferred patients, and providing for appropriate clinical and administrative supervision of transferred staff. A joint SEH-D.C. staff group is working on resolving all issues so that there will be no decline in the quality of patient care caused by the staff reassignments. As required by Public Law 98-621 there will be 30 day advance notice for the Congress before any such reassignments go into effect.

Mr. Conte. You know for the past several years I've been following the activities of the William White Division where the NIMH is conducting a number of intramural research studies. What are you requesting for this activity in the FY 1987 budget, and what will happen to this research after the hospital reverts to the District?

Dr. Frazier. Our budget request for payment to Saint Elizabeths Hospital includes $3,891,000 for logistical support provided by the hospital to the NIMH William A. White operation. As you know, this research has been highly productive over the years of its location on the grounds of the hospital, which predates the transfer of the hospital to the Institute. Currently, the William A. White facility conducts basic research on special mental health problems such as aging and schizophrenia, and investigates normal and pathological processes in psychopharmacology and memory.

Provision of Public Law 98-621, "The Saint Elizabeths Hospital and the District of Columbia Mental Health Services Act", authorizes the retention of real property on the St. Elizabeths Hospital grounds as necessary for Federal mental health programs. Accordingly, we have provided a preliminary notice to the District government of our intent to retain the William A. White building with the adjoining animal house for conduct of intramural research.

Mr. Conte. I believe I remember seeing a deferral last year of about $6 million in unexpended construction funds at Saint Elizabeths. Are there any unexpended funds in the Saint Elizabeths account?

Dr. Frazier. There was a total of $8.5 million unobligated last year. The bulk of this money is still available.

MENTAL HEALTH SERVICES TO THE ELDERLY

Mr. Roybal. What progress has been made in determining the number of elderly estimated to be in need of community mental health services and in increasing the focus and caseloads of community mental health center services to the elderly, pursuant to House report language under the 1986 appropriation?

Mr. Trachtenberg. Our most recent survey data indicate that the elderly make up only 1.6% of the caseload in the residential treatment services of community multi-service mental health organizations which include Community Mental Health Centers. We also know that the elderly make up only 6.2% of the clientele in the outpatient services of community multi-service organizations. Generally when the percentage of elderly in the caseload is less than 11.8% (the estimated percentage of those aged 65 and over in the United States civilian population), then the elderly are underrepresented within that service.

Two grant programs have been utilized to increase CMHC focus on the elderly: The new State Comprehensive Mental Health Planning Grant Program which was implemented in 1985 gave a priority to State planning to improve services to the elderly. Four of the 11 States which received these new State planning grants are putting an emphasis on improving community services to the elderly. In addition, the new mental health service demonstration program announcement which was issued by NIMH in January 1986 includes the elderly mentally ill as one of three target populations. New proposed projects for demonstrating innovative community services for the elderly are due by April 1, 1986. We hope to fund at least six new projects which focus on the seriously mentally ill elderly.

Mr. Roybal. Within the limitations of the block grant authority, what initiatives has ADAMHA undertaken to address the elderly's seemingly low utilization of CMHCs?

Mr. Trachtenberg. In addition to the priority on the elderly under State Mental Health Planning Grants and Service Demonstration Grants, a new contract was let with the National Council of Community Mental Health Centers in Fiscal Year 1985 to develop and provide technical assistance to Community Mental Health Centers on improving services to the elderly and other underserved groups. We plan to let an additional contract in this area in FY 1986. When participating in State Block Grant Compliance Reviews, NIMH staff pay special attention to the extent to which States are giving a priority to the elderly in their allocation of block grant resources. In addition, beginning with Fiscal Year 1986, in keeping with Section 1920(2) of the Alcohol, Drug Abuse, and Mental Health Amendments of 1984, each State will be asked to report annually on the number and percentage of elderly being served in State-supported CMHCs. This report also will include information on the services available to the elderly and the sources of funds for these services.

Mr. Roybal. What is the estimated number of Alzheimer's patients who themselves or their families benefit from community mental health services?

Mr. Trachtenberg. From our recent survey data, we know that the elderly (65 years and older) comprise 1.8 percent of those in residential treatment and 4.8 mental health organizations which are largely CMHCs. We also know that the elderly comprise 6.2 percent of the caseload of these multi-service mental health facilities. Our survey, however, is not sufficiently sensitive to detect what number or percent of the elderly population was seen because of Alzheimer's Disease, nor does it collect data on services to nonpatient family members.

Mr. Roybal. What proportion of those in need are currently being served?

Mr. Trachtenberg. We do not have any data which can document the proportion of persons with Alzheimer's Disease that are being served.

Mr. Roybal. Within the limitations of the Block Grant authority, what initiatives has ADAMHA undertaken to address the need for these services?

Mr. Trachtenberg. Alzheimer's Disease is largely a disease of the elderly. The priority focus on the elderly would, therefore, include this population in the new State Comprehensive Mental Health Planning Grant Program as well as in the contract with The National Council of Community Mental Health Centers to develop and promote technical assistance to CMHCs to improve their services to the elderly.

Mr. Roybal. What progress has been made in increasing the focus and caseloads of comminity mental health center services to meet the needs of Alzheimer's victims and their families?

Mr. Trachtenberg. The following information demonstrates progress being made with regard to Alzheimer's patients and their families:

o CMHC caseloads for the elderly have not grown overall, but there is more variability among patients; in a 1984 national survey carried out by the National Council of CMHC's, responding Centers report an average of 10.6% of their caseloads as over age 60. Centers with specialized geriatrics programs and especially trained staff report caseloads of 15.8% for the over 60, while Centers with neither report caseloads of 7.2% over age 60.

- **Specialized Alzheimer's Disease programs in CMHC's are rare, but over half the Centers report providing consultation to caretakers or families.**
- **Alzheimer's Disease was identified as a high priority area for further information and future program development in a majority of Centers.**

Mr. Roybal. How will ADAMHA's five clinical research centers for the elderly be affected, either directly or indirectly, by the elimination of the clinical training program?

Mr. Trachtenberg. Each of the five clinical research centers for the elderly has had separate support for clinical training and has both benefited and been benefited by these clinical trainees. Clinical trainees have contributed directly to the research effort on the elderly at these institutions and have gained essential research experience and training by virtue of being associated with these centers. With the elimination of the clinical training program this reciprocal advantage will be lost. The clinical research centers do not depend on clinical training grants to carry out their programs of research and will continue to function much as before, although the additional benefits due to the complementary nature of these two mechanisms will be lost.

NATIONAL INSTITUTE OF MENTAL HEALTH

Mr. Roybal. What portion of the ADAMHA funding was devoted to research on Alzheimer's disease in 1985 and will be devoted to it in 1986 and 1987? Please indicate the funding level by project type.

Mr. Trachtenberg. We spent $5,750,000 in 1985. We expect to spend $5,742,000 in 1986 and $5,656,000 in 1987. It might also be helpful to relate the expenditures for Alzheimer's disease to the total budget for aging, as the two are very much interrelated.

	1985	1986 Revised	1987
Extramural Research:			
Alzheimer's Disease	$5,050,000	$5,043,000	$4,957,000
Other Aging Research	2,429,000	3,231,000	3,091,000
Total Extramural....	7,479,000	8,274,000	8,048,000
Intramural Research:			
Alzheimer's Disease.	700,000	699,000	699,000
Other Aging Research	3,120,000	3,176,000	3,566,000
Total Intramural....	3,820,000	3,875,000	4,265,000
Total Research for Aging............	11,299,000	12,149,000	12,313,000
(Alzheimer's Disease)	(5,750,000)	(5,742,000)	(5,742,000)

CLINICAL TRAINING

Mr. Roybal. What proportion of clinical training funding went to minority individuals or institutions?

Mr. Trachtenberg. In 1985, $3,277,000 or 10.9 percent of the total level of $29,998,000 for clinical training was spent for minority individuals or institutions. This amount included $1,050,000 for portions of the Minority Fellowship Program, and $2,227,000 for grants to minority individuals or institutions. No clinical training funding would be available in 1986 or 1987, as this program is proposed for rescission and phasing-out.

Mr. Roybal. What evidence is there that there are adequate numbers of minorities now trained to justify eliminating the program?

Mr. Trachtenberg. The number of trainees has grown considerably since this program peaked out in 1969-70. At that time our budget for clinical training was about $100 million a year. Some students are gaining support from areas other than the Federal sources and it is our feeling that after many years of Federal support we should be seeking to shift that responsibility to other institutions.

Mr. Roybal. What progress has been made in clinical training curriculum to prepare mental health professionals to meet the needs of an aging population and of Alzheimer's victims and their families? Please provide information on the relevant projects or activities.

Mr. Trachtenberg. In recent years NIMH's clinical training support has been restricted to programs that focussed on priority target areas. One of these has been the aging population. Several projects involve preparation of new curriculum material to train mental health professionals for work with aging patients, with Alzheimer's victims and with their families.

Mr. Roybal. What assurances can you provide that the elimination of the ADAMHA clinical training program will not jeopardize our ability to deal with relatively new issues, such as the growing elderly population and Alzheimer's disease?

Mr. Trachtenberg. While no absolute guarantee can be proved in this regard, increasingly medical school and other training institutions are stressing preparing mental health professionals for work with elderly persons and with Alzheimer's disease.

Mr. Roybal. If funding is restored, what efforts will be made to improve and expand clinical training in geriatrics?

Mr. Trachtenberg. NIMH has earmarked funds to improve and expand clinical training in geriatrics. Staff have been consulting with a number of potential applicants and several quality projects in this area have already been received and currently are being reviewed.

Mr. Roybal. Given that ADAMHA has decided to increase the percentage of funds going to priority areas--including mental disorders of the aging--while the totals have decreased from 1985, what is the net effect of both factors on the funding and program level?

Mr. Trachtenberg. There will still be a net increase of 8.8 percent over the 1985 spending level for the priority areas of basic brain studies, schizophrenia, aging, and mental disorders of children. This translates into an increase of $10.1 million over 1985. When compared with the 1986 Gramm-Rudman level, there is a drop of less than one half of one percent.

NIMH RESEARCH PRIORITIES

Mr. Roybal. Several research priorities -- basic research, schizophrenia, aging and children -- were named by NIMH in the FY 87 budget. Why were they selected?

Mr. Trachtenberg. These research priorities were selected because they offer the promise of significant advances or because there is a critical need to develop the knowledge base related to them.

Basic research in the neurosciences and behavioral sciences is essential to the development of the knowledge base that will enable us to understand, diagnose and treat the mental disorders that afflict about 30 million Americans of all ages. The neurosciences are making significant progress in specifying the neuronal functions that are key to understanding the brain mechanisms serving behavioral responses. Progress also is being made by the behavioral sciences in the exploration of cognitive processes and emotional development, but this effort needs to be expanded.

Schizophrenia remains the most complex, puzzling and, because of its tendency toward chronicity, the most severe of the major mental illnesses. With a lifetime prevalence of 1 percent of the general population, 2-3 million Americans are affected by this disorder. Although neuroleptic medication helps many of these individuals, at least 50 percent experience some form of intermittent disability throughout their lifetime and another 25 percent never recover from the initial episode and require life-long care. A renewed effort in this area is required to answer many of the questions related to the heterogeneity of the illness, its core symptoms, and its treatment. New technology, such as the brain imaging techniques, has expanded the ability of researchers to probe more deeply into the causes of this disorder.

Elderly Americans (age 65 and over) number over 27 million or 11 percent of the population; estimates covering the next 40 years project the growth to 55 million, fully 20 percent of the population. The dementias including Alzheimer's disease represent a devastating problem in this population that can only become worse as the "graying of America" moves into high gear. Unfortunately, much of the existing information about brain function, behavior, and mental disorders may not apply to older adults for a number of reasons. First, the information is based on research on young and middle-aged adults. Second, a number of physiological changes in brain function accompany the aging process. And third, dramatic psychosocial changes which impact on the elderly have occurred in this country over the past decade.

Recent research has clearly demonstrated the importance of age as a primary variable. For instance, studies suggest that certain widely used tricyclic anti-depressants can induce marked memory and learning impairment in elderly subjects. Other research indicates that age-related changes in the performance of psychoactive drugs could lead to serious adverse reaction in the elderly if dosage and scheduling are not adjusted to compensate for these changes. Research further indicates that special care needs to be taken in interpreting many neuroendocrine test results in aged patients to determine whether abnormal measures are related to age or mental illness.

An estimated 12 percent of youngsters under age 18—some 7.5 million--are subject to various child and adolescent disorders at any given time. These disorders include autism, schizophrenia, depression, anxiety, attention deficit disorders, conduct disorders, psychiatric disorders occuring in the mentally retarded and developmentally disabled, and psychophysiological illnesses such as anorexia and bulimia. Despite the dimensions of this problem area, research on these disorders has lagged behind research on adult psychopathology, partly because the existence of severe mental illness in this group has only recently been recognized, but also because of the limited number of adequately trained researchers and limited resources. Major knowledge deficits exist about the etiologies of these illnesses, their assessment and measurement, and their treatment.

Mr. Roybal. How much of the budget is allocated to those priorities?

Mr. Trachtenberg. The four priorities just mentioned are compared with the total research budget in the following table:

Priority	1985	1986	1987
Basic Brain & Behavior.	$64,014,000	$69,447,000	$68,801,000
(% of total).....	(33.1%)	(34.4%)	(35.3%)
Schizophrenia..........	18,456,000	21,138,000	21,125,000
(% of total).....	(9.6%)	(10.3%)	(10.9%)
Aging..................	11,299,000	12,149,000	12,313,000
(% of total).....	(5.8%)	(6.0%)	(6.3%)
Child Mental Health....	21,190,000	23,047,000	22,848,000
(% of total).....	(11.0%)	(11.3%)	(11.7%)
Subtotal, priorities...	114,959,000	125,781,000	125,087,000
(% of total).....	(59.5%)	(61.6%)	(64.2)%
Other programs.........	78,369,000	78,367,000	69,803,000
(% of total).....	(40.5%)	(38.4%)	(35.8%)
Total programs.........	193,328,000	204,148,000	194,890,000
(% of total).....	(100.0%)	(100.0%)	(100.0%)

Mr. Roybal. Will they be protected from any cutbacks?

Mr. Trachtenberg. Some reduction below the 1986 level of effort will be necessary. However, priority research will be cut at an average rate of less than one percent below the 1986 Gramm-Rudman level, as opposed to other areas which will be reduced by nearly 11 percent.

Mr. Roybal. The Administration again proposes to terminate all support for clinical training, including the well-documented shortage areas of child and geriatric mental health, assistance to minority students, and grants to State for comprehensive mental health human resource planning. What new evidence do you have that these needs have been met?

Mr. Trachtenberg. Increasingly academic institutions and States are targeting their training funds on child and geriatric populations, and the needs for minority trainees. In addition, State mental health authorities now realize the importance of comprehensive planning for the human resources needs.

NIMH CLINICAL RESEARCH CENTERS

Mr. Roybal. What has been the scope of the NIMH Clinical Research Centers Program?

Mr. Trachtenberg. As background, you may wish to know that the Research Centers Program of the NIMH consists of three types of Centers: the Clinical Research Centers program, established in 1977; the Prevention Intervention Research Centers, established in 1983; and the Clinical Research Centers on Psychopathology of the Elderly, established in 1984. I will limit my answer to your question concerning the Clinical Research Centers (CRC).

This is the largest of our centers programs and consists of 13 CRCs in 12 universities and 9 States mainly on the east and west coasts. In aggregate they study child and adult mental disorders looking for answers to questions on the causes, diagnosis, and treatment of specific mental disorders. Substantively they investigate a very broad range of biological, genetic, pharmacological, electrophysical, and psychosocial questions, relationships, and factors that may be implicated in mental disorders. Most of the CRCs emphasize biological and psychobiological theories and approaches to the investigation of the mechanisms that may underlie mental disorder. They use biological, pharmacological as well as psychological probes that have implications for treatment. In general the CRCs invariably focus on issues of treatment and responsiveness to different types of interventions. While some of the centers are dedicated to specific disorders (schizophrenia-2, affective disorders-2, childhood disorders-1), the majority of these centers (8) have multiple foci and therefore study more than one mental disorder. The disorders covered include schiozphrenia, depression, anxiety disorders, child and adolescent disorders, as well as "organic" disorders. These centers attempt to integrate the substance and methods available in the basic neurosciences, behavioral sciences and clinical sciences in the study of psychiatric disorders.

Unlike regular project grants which provide funds for specific research projects, the CRCs provide a broad base of support for necessary human and material resources to facilitate cooperation among investigators from several and different disciplines by providing core laboratory, statistical, diagnostic, clinical assessments, research beds and computer resources for several research projects which may be independently funded through Federal, State and private funds. The centers have in common the secondary goal of providing liaison and consultation to mental health professionals in their immediate community. Some offer, in addition, extensive educational programs, but the costs of many of the training and educational functions are not covered by the CRC grants.

Mr. Roybal. What is your overall evaluation of the clinical research centers program in terms of NIMH goals and priorities, research scientist training, and spin-offs to training of practitioners and clinical services?

Mr. Trachtenberg. In my opinion, and this is based on considerable consultation with many leaders in the field, the NIMH CRC program represents one of the best and most successful support programs of the Institute. It meets some very special needs and requirements of the mental health clinical research community which are not met by any other support mechanism. It invests funds in some of the most creative and productive of our established scientists, supports the work of several groups of investigators enhancing their research environments and the possibilities of collaboration among them. The CRCs are awarded to some of our most advanced research institutions and outstanding universities.

The substance of the research is, in aggregate, very much in line with the Institute's research goals and priorities in basic and clinical sciences. These centers provide excellent research training for young investigators and, as a result, have been responsible for a notable increase in the number of new research projects submitted and approved from institutions that have these centers.

Traditionally, most of the centers have been supported at levels far below those recommended by our review and advisory groups because of limitations on available funds and we have not been able to increase the ceiling on the total costs of CRC awards since 1977. As a consequence, many of the secondary and tertiary goals of the CRCs in the areas of clinical training of practitioners, broader technical consultation and liaison with mental health professionals in the community and broader educational functions have not been as fully addressed as these centers are very capable of doing. Much of the clinical and research training, community liaison, and educational functions that these centers have been able to undertake has been due not to our support but due to support from state, university and private resources. I must point out, however, that both the clinical and research training programs run by investigators directly involved in these centers represent some of the best offered in this country.

Mr. Roybal. What are the benefits of a research program over a project grant?

Mr. Trachtenberg. Typically a project grant supports the work of one established investigator who is interested in a very specific set of questions (e.g., is treatment A more or less effective than treatment B for a particular type of mental illness?). The project is typically carried out in a relatively short and foreseeable period of time (2-5 years). The work is carried out in a single laboratory or clinical setting, often within one scientific discipline (e.g., pharmacology, psychology, psychiatry), with the help of limited support and technological staff and resources. The cost of a project grant is typically lower than a program project or a center grant.

In a CRC there are typically several studies, some independent and some related to other projects within the program, most of which will have a common theme. As a program, some of these studies may be carried out concurrently and others sequentially based on findings and leads from earlier efforts. There are several established investigators who interact with each other representing basic neurosciences, behavioral sciences and clinical disciplines whose joint expertise and skills are needed to carry out the program. Therefore the centers can attack larger problems. By virtue of collaborative work in developing a center program and then by providing core support to all center investigators in the form of laboratory facilities, patient selection, screening and assessment, statistical and computer resources and the like, the centers facilitate the integration of the work of several investigators and also provide efficient and cost-effective ways of meeting the infrastructure needs of several researchers. In addition, because of the significantly larger number of subjects that are studied under a center program, cross-validational and method development studies are easier and more feasible to mount under such programs. Because of some of these features already enumerated, the centers are in a position to provide high quality diagnostic workshop, state-of-the-art laboratory procedures and sophisticated statistical data design, analysis and management. They provide some of the best quality of research training for junior colleagues and students and, on the whole, contribute significantly to the educational program of the department in which the center exists. In terms of substantive scope of the research, the individual project grant has clear-cut specific goals and methods and expected completion time. In larger programs such as those of the centers, the goals are both short-term and long-term and the areas of investigations are many. Therefore, there is a greater flexibility for changing the course of research on the basis of the data at hand. One other point - research is undoubtedly a high-risk enterprise, but the risk of failure and lack of productivity is minimized in the case of research centers since they are awarded to only investigators with established records of excellence and productivity.

Mr. Roybal. What new initiatives are you planning in this area?

Mr. Trachtenberg. In line with the Institute's priorities for the next few years, we are encouraging the development of additional new Clinical Research Centers in schizophrenia, child and adolescent mental disorders and psychopathology of the aging in 1988. Our ability to actually implement these initiatives will rest on the level of the 1988 budget.

Mr. Roybal. Have clinical research centers proven their cost effectiveness in producing new and important findings regarding mental illness?

Mr. Trachtenberg. Based on a review of the Clinical Research Center (CRC) program conducted in FY 1985, the answer is yes. The Center program has been successful in providing a stimulating and productive research environment for interdisciplinary teams of scientists. Investigators associated with CRCs have established a record of significant scientific productivity, most clearly illustrated by the more than 3000 scientific publications they produced in the previous five years. The findings reported in these publications constitute an impressive addition to the body of knowledge about the classification, etiology, mechanisms, treatment and prevention of mental disorders.

Mr. Roybal. Please give some examples of accomplishments emanating from centers.

Mr. Trachtenberg. The scientific output of the CRCs contains many findings of great importance for understanding and treating psychiatric disorders.

The Stanford University center has discovered that the narcotic antagonist, naloxone, decreased schizophrenic hallucinations, suggesting that such hallucinations may be caused by the brain's own morphine-like compounds, endorphins. Establishing this connection between endorphins and hallucinations is a significant step toward understanding the biological basis of schizophrenia and developing practical treatments for it.

The McLean Hospital center in Boston has demonstrated that specific cognitive and neurophysiologic dysfunction, i.e., inability to visually track a moving object, is common in schizophrenic patients. These abnormalities may provide clues as to the site of brain dysfunction in schizophrenia.

The Chicago center has shown that the negative symptoms of schizophrenia like flat affect, retardation, and loss of interest, respond less favorably to neuroleptic medication than do the positive symptoms, like hallucinations. Partialing out the symptom complexes of schizophrenia and assessing their response to various drugs is an important process in tailoring treatment to symptoms.

The UCLA center has developed a form of social skills training that produces durable improvements in interpersonal abilities for schizophrenia patients. Such abilities probably play a crucial role in maintaining adequate functioning in the community, and protect against relapse after discharge from the hospital.

The New York University center has used positron emission tomography to show that depressed patients have decreased metabolic brain activity. This evidence of altered brain function in depressive illness is an important clue to the biological basis of this major disorder.

The University of California center in San Diego has shown that increasing brain acetylcholine with a drug called physostigmine can cause a brief depression. Patients with depression and mania were more reactive to the effect of physostigmine than were normals or patients with other disorders. This study suggests that patients with depression may have too much acetylcholine in their brains, and that drugs that antagonize acetylcholine might alleviate depression.

At the Washington University center, an adoption study has shown that depressive disorders are heterogenous in genetic and environmental causes. Non-psychotic depressions before age 30 are largely environmentally determined as shown by psychopathology in depressed adoptees, but not in their biological parents. In contrast, depressives with later onset are more likely to have biological parents with depression despite the children having been adopted during infancy. Depression with such different causes are likely to require different treatments.

The University of North Carolina center has shown that the response of children with attention deficit disorder to the drug, Ritalin, can be predicted from their pre-drug behavioral state, but not from blood-levels of the drug. This finding is leading investigators to reexamine current theories of attention deficit disorder.

At the University of Pittsburgh center, researchers have shown that psychosocial deficits and impairments in relationships associated with major depression in pre-pubertal children do not seem to improve with pharmacological treatment. Such a finding suggests the need for social skills training in these patients, training that has been shown to be quite useful in schizophrenics.

Centers also are developing promising research leads related to the understanding and treatment of anxiety disorders, Alzheimer's Disease, Tourette's Syndrome, and other psychiatric and behavioral problems.

Mr. Roybal. What impact have the research centers had on the local communities with regard to improving professional training and services and providing information and education to families of the mentally ill?

Mr. Trachtenberg. The impact of these centers on local professional and lay communities has been impressive. The excellent work of the CRCs in this context is reflected in providing the latest research findings and data relevant to the diagnosis, causes and treatment of the disorders being studied by the centers. Typically, they provide continuing education courses for the professional community, conduct regular scientific seminars for trainees at pre- and postdoctoral levels in psychiatry, clinical psychology, psychiatric social work and psychiatric nursing. The CRC staff also provides consultation to individual clinicians and often work closely with interested family groups. For example, the Clinical Research Center at UCLA, focusing on childhood psychoses and autism, has established extensive contacts with various community clinics and treatment and educational centers for autism and has worked extensively with organized national and local citizen's groups concerned with autistic children and adults. The Clinical Research Centers at Yale provides extensive educational programs and consultation in both child and adult psychoses, offers excellent scientific training programs for professionals and also works regularly with several patient/citizen groups. Similarily, the Clinical Research Center at the University of Pittsburgh has an extensive educational/consultative program, a unique feature of which is a regular television program providing information on the latest research findings in the areas of affective disorders and sleep disorders.

Mr. Roybal. In considering renewals, how are clinical research centers evaluated and what criteria are used?

Mr. Trachtenberg. Applications for the renewal of clinical research center grants are reviewed using essentially the same criteria as those used for applications for initial support. For renewals, added emphasis is placed on the achievement of the conceptual, organizational, or research goals specified in the prior application approved and funded by the NIMH.

Both new and renewal applications for clinical research center grants are evaluated for scientific merit by special peer review committees that operate under the same basic guidelines as other initial review groups. Special review criteria have been established for center grants in addition to those used for individual project grants. The size and complexity of center grants requires that they be reviewed by a sufficiently large group of high caliber scientists to cover all of the specialities involved and that the reviewers visit the proposed research site to obtain first-hand information to be used in their evaluation. Review criteria include: potential contribution to mental health/public health knowledge; scientific and technical merit, level of training, experience, competence and productivity of research personnel; level of training, experience, competence, productivity, commitment, and authority of the center director; staff balance and potential for cooperation and collaboration among staff; availability of research subjects and materials; capacity to provide a variety of training opportunities; adequacy of facilities and environment; adequacy of administrative support; potential to become a regional or national resource; and appropriateness of budget estimates.

As with all other grant applications, following the initial review summary statements are given a second review by the National Advisory Mental Health Council which considers policy issues and makes a final recommendation to the Director of the Institute. Funding decisions are based largely on the outcome of this peer review process although NIMH program balance and availability of funds are, of course, also taken into account.

Mr. Roybal. How much weight is given to productivity in making your decision?

Mr. Trachtenberg. Productivity is a very important criterion in the evaluation of the progress of a renewal application, although in some circumstances it may weight more heavily than in others. For example if a center has only been in existence for a year since a renewal application was prepared, level of productivity may be judged less critically than in the case of a center with a longer history of grant support. Nonetheless, productivity is probably the most clearly observable evidence of the success of a research effort and it is considered a very significant factor in evaluating a renewal application.

Mr. Roybal. How does the peer review process for clinical research centers differ from the process for individual project grants?

Mr. Trachtenberg. Although the same basic process is used in the review of individual research grants and clinical research centers, there are some important differences. Because clinical research centers often address a problem area in great depth and are on a very different scale than individual project grants, standing review committees are not well suited for their review. Thus special committees are constituted that are composed of senior investigators specifically involved in the program area to be studied. The size and complexity of clinical research centers and the applications and supporting materials to be reviewed requires a site visit by the reviewers. In the case of individual project grants, site visits are only made occasionally, and only when specific information is needed to make a judgment about the merits of a project. Finally, the review criteria for centers include a number of factors not used in individual project grants. Criteria unique to the evaluation of center grant applications include: level of commitment and authority of the center director; staff balance and synergistic potential for collaboration and cooperation among investigators from various disciplines; capacity of the proposed center to provide a variety of quality research preceptorship and training opportunities; and potential for the proposed clinical research center to become a regional or national resource.

MINORITY TRAINING AND RESEARCH

Mr. Roybal. What is the impact of the NIMH reorganization on minority research training.

Mr. Trachtenberg. Under the reorganization, we have consolidated all minority research training under one branch. This means that all these programs are together so that we can keep a strong monitoring control of them.

Mr. Roybal. What specific steps has the Institute taken to assure that minority research and researchers will not suffer or be reduced?

Mr. Trachtenberg. For NIMH minority research in fiscal year 1985 there were 144 grants at $21.7 million. This represents all grants with any degree of minority relevance. We expect to remain stable at this level in fiscal years 1986 and 1987. To appropriately address the needs of minorities in research, knowledge transfer, and national leadership efforts, the ADAMHA Administrator established a set of goals to be incorporated into the ongoing activities of its component Institutes--NIDA, NIAAA and NIMH. Six areas in which minority goals have been established are research, epidemiology, demonstration programs, technical assistance, knowledge transfer and dissemination, and training. Each Institute has developed a dynamic and challenging plan which addresses each of these goals. These Institute plans constitute the components of ADAMHA's minority strategy. An outstanding feature of this initiative is its definition of challenging yet attainable goals. To ensure that these program activities are implemented, an accountability mechanism has been initiated through the annual performance plans of all appropriate staff. Coordination and program surveillance will be managed by the NIMH Associate Director for Special Populations/ADAMHA Coordinator for Special Populations.

Mr. Roybal. In the Black and Minority Health Task Force Report, the category of homicides and accidents has been identified as one of the six major health problems in minority populations. Has NIMH made any specific plans to deal with this problem?

Mr. Trachtenberg. The Black homicide issue is one of the 1990 objectives, and our branch in Antisocial and Violent Behavior is looking at the problem of Black homicide. We have conducted research in the past on homicide and other forms of violence. We are actively involved in minority and Black issues relevant to homicide. In the fall of 1986, the NIMH will co-sponsor a research-based conference at Johns Hopkins University School of Public Health. The objectives of this conference are: (1) to foster increased awareness and understanding of Black homicide as a public health problem, (2) to present results of the most recent research in this area; (3) to examine the current state-of-the-art with respect to prevention and intervention; and (4) to develop recommendations for future research and action.

Mr. Roybal. What other report recommendations do you plan to implement in FY 87?

Mr. Trachtenberg. The Institute will develop special research activities focused on minority needs and encourage participation of minority researchers. In the area of epidemiology, our data collection and analysis activities will include appropriate and adequate sampling of minorities to identify the relative incidence and severity of mental health conditions among minority populations. We will continue to give high priority to knowledge transfer and dissemination activities that focus on the mental health needs of minorities.

ALZHEIMER'S DISEASE

Mr. Roybal. What progress has NIMH made in addressing the Committee's expressed concern regarding family stress problems and service delivery models for care of Alzheimer's Disease victims?

Mr. Trachtenberg. In April 1985 the National Institute of Mental Health issued a specialized Research Grant Announcement, "Research on Family Stress and the Care of Alzheimer's Disease Victims" soliciting applications on this topic.

The specialized announcement solicits applications which focus on the generation of systematic information on: the nature, consequences, and interplay of stress associated with caregiving; factors associated with understanding and enhancing family support; the identification, treatment, and management of excess disability in Alzheimer's Disease (AD) patients and strategies to maximize their functional level at all stages of the disease; the prevention of psychopathology and the promotion of mental health among family caregivers; and research on the design and delivery of services providing treatment and clinical interventions for individuals with AD and for the family members who care for them.

Applications under this specialized announcement continue to be solicited and grants continue to be submitted to the National Institute of Mental Health. In FY 1985, six (6) projects were funded with total costs of $841,257.

AIDS

Mr. Roybal. What research related to behavioral and neuropsychological aspects of AIDS has been supported by NIMH?

Mr. Trachtenberg. In FY 1985, NIMH provided support for 17 research projects totaling $1,302,000. Several longitudinal studies of gay and bisexual men are being carried out in New York City and San Francisco, the highest AIDS incidence centers, and in Chicago. These focus on the biobehavioral, and neuropsychiatric aspects of AIDS.

Studies are currently supported which focus on men diagnosed as having AIDS or AIDS-Related Complex (ARC) to examine the psychosocial consequences of the disease. A key finding reported is that psychosocial consequences of ARC were different from and more severe than those of AIDS. Men with ARC were more psychologically distressed and reported more negative mood states than those with AIDS.

An investigator at Sloan Kettering working in conjunction with NIMH grantees has recognized that afflicted patients frequently suffer a variety of central nervous systems (CNS) complications. While some of these are well recognized opportunistic conditions, much more common is a progressive encephalopathy referred to as AIDS dementia, which has not previously been described in other immunosuppressed patients. In adults this encephalopathy characteristically manifests as a subacute dementia accompanied by motor dysfunction. In its early stages, AIDS dementia is marked by a general slowing in thinking, memory, and motor functions. Changes in personality may also be present, along with apathy, withdrawal, and loss of interest in socialization. Organic psychosis also occurs at the earliest stages, although less frequently than the less dramatic symptoms. Moderate to severe global cognitive dysfunctions may appear within three months of the appearance of the first symptoms. The hallmarks at this late stage are global cognitive impairment and psychomotor slowing. Only rudimentary intellectual and social functioning remains. Patients typically die of intercurrent infection.

ELDERLY

Mr. Roybal. What is the status of the program concerning Research Centers on Psychopathology of the Elderly?

Mr. Trachtenberg. There are five active Clinical Research Centers on the Psychopathology of the Elderly. Two of these are due for renewal this fiscal year and have already been through peer review. One has a good priority score and is likely to be funded, the other a relatively poor priority score (213) and is unlikely to be funded. In addition, two new applications were submitted which were approved with good priority scores. Neither of these new applications has been funded.

Mr. Roybal. How many centers are funded?

Mr. Trachtenberg. There are currently five clinical research centers for the elderly. Three of these were first funded in FY 1984, and two were added in FY 1985. Total costs in FY 1985 amounted to $1,600,000. Three of the five have future year commitments, two have pending competitive renewals.

Mr. Roybal. How many centers are approved but not funded? What is the cost?

Mr. Trachtenberg. At the present time there are four approved but unfunded applications for clinical research centers for the elderly. Two of these are new applications and two renewals. Of the two renewals pending, one has a poor priority score (213) and we do not plan to fund it, the other we hope to fund. The two new applications both have good priority scores and if we had sufficient funds we would pay them. The three applications which are approved and unfunded that are of high scientific merit amount to $1,664,000 total costs for the current year. The application with a poor priority score would cost $360,000 for the current year.

AIDS

Mr. Roybal. What have you done to foster cooperation between your Institute and other PHS programs relating to AIDS?

Mr. Trachtenberg. NIMH has taken the lead in issuing with NIDA and NIAAA a joint Request for Application to stimulate AIDS research. Currently, more than 30 proposals have been received. It is anticipated that at least 5-10 new grants will be awarded as a result of this activity. One cycle of reviews has been conducted, with 4 projects recommended for funding consideration. A special review will be held in the late spring or early summer to permit funding before the end of FY 1986.

NIMH and NIDA also plan to make awards for two or three AIDS research centers to provide a structure for bringing research and dissemination activities into a coordinated unit. The centers are conceptualized as facilitating the rapid dissemination of new knowledge into clinical practice, and to the research and training communities. Centers may request up to $500,000 per year over a five year period. Currently, 10 expressions of intent to submit center grant applications have been received.

NIMH is planning to collaborate with the NIH, NIDA, NIAAA, CDC, and FDA in sponsoring a conference related to AIDS Co-Factors. The conference is scheduled for April 7-9, 1986.

NIMH is also planning to sponsor a conference with NIDA and NIAAA concerned with the neuroscience and behavioral science aspects of AIDS. This conference is scheduled for May 29-30, 1986. NIMH is also participating in the NIH Consensus Conference on the HTLV-III Blood Test in July 1986.

NIMH plans to bring together the investigators currently supported who are developing inventories which measure psychosocial and mental health aspects of AIDS. A workshop to synthesize findings and to identify areas in need of future research is planned for August 1986.

PREVENTIVE EDUCATION EFFORTS

Mr. Roybal. What progress has been made on research to maximize preventive education efforts and what role has ADAMHA played in this area?

Mr. Trachtenberg. Research to maximize preventive education efforts is currently under way. There are several studies investigating the psychosocial aspects of AIDS. Within the population group most affected, gay men, basic information is needed on the specific sexual activities, and their motivations, that place them at risk. Understanding the meaning and value of gay sexual behavior opens the possibility of changing it, and changing risk-related individual and group behavior offers the best prospect of prevention.

There is a considerable body of evidence indicating that psychosocial factors play direct and indirect roles not only in recovery from illness, but also in the onset of the disease.

Although current knowledge of AIDS and awareness of "safe sex" guidelines about risk factors were uniformly high, such information was not consistently used by gay men as a basis of change. Sexual behavior does not fit the health belief model used in other (e.g., smoking, diet) public health campaigns. Based on objective risk data, and extension to men still at risk--these objectives may require efforts targeted to specific components of the gay community, notably individuals who have been in the gay lifestyle for more than 9 years.

Public health educators and physicians counselling patients need to inform their efforts with understanding of the values and meaning of specific aspects of gay sex that are emerging from body of research. Continuing the current "safe sex" focus is insufficient. They recommended that (1) health education efforts build on the momentum of behavior change already accepted by the gay community, (2) programs to promote condom use be mounted, (3) health messages sound the theme of social responsibility among high-risk men, and (4) emphasize that even if one has already been exposed to HTLV-III, it may be important to protect against additional infection.

PUBLIC PSYCHIATRY

Mr. Early. Provide a comprehensive list of the public psychiatry initiative grant recipients for each year of the program and the amount of each grant.

Mr. Trachtenberg. The list follows. All awards were made initially in FY 1984 for a three-year period. Awards for FY 1986 have not yet been made, but are expected to be the same as those in previous years. The program will not be funded in FY 1987.

Institution	Fiscal Year of Award 1984	1985
Harvard Medical School	$18,931	$18,931
U. of Massachusetts Medical School	30,586	30,586
University of Maryland	32,578	32,578
U. of Illinois at Chicago	23,809	23,809
Southern Illinois University	29,777	29,777
Medical College of Georgia	18,491	18,491
U. of Texas Health Sciences Center	24,258	24,258
Emory University	27,330	27,330
University of Pittsburgh	32,173	32,173
University of Virginia	29,212	29,212
University of North Carolina	32,986	32,986
Oregon Health Sciences University	22,013	22,013
Butler Hospital	17,610	17,610
U. of Colorado Health Sciences Center	18,246	18,246

AIDS AFTER SEQUESTER

Mr. Early. Please provide a breakdown of how the NIMH plans to utilize the FY 1986 post-sequestration appropriations level for AIDS related activities.

Mr. Trachtenberg. A summary by budget activity and mechanism is provided in the following table.

Activity & Mechanism	Awards	Amount
Research:		
Project Grants:		
Continuations...............	9	$1,354,000
New.........................	7	861,000
Total Project Grants......	16	2,215,000
Other Mechanisms:		
Research Centers (new)......	2	478,000
Research Scientist Development:		
Continuations.............	2	100,000
New.......................	1	55,000
Total Res. Scient. Develop.	3	155,000
Small Grants..................	1	50,000
Contracts.....................	8	805,000
Total Research...........	30	3,703,000
Direct Operations Contracts and Support Costs................	--	1,348,000
Total.........................	30	5,051,000

HOMELESS

Mr. Early. It is well recognized that a large number of the homeless population is chronically mentally ill, and that many of these people have fallen through the very large cracks in the mental health services delivery system. How, and to what extent, is NIMH and the Department working either alone or with other federal agencies to combat this severe problem?

Mr. Trachtenberg. In January 1983, the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) established a focal point within the National Institute of Mental Health (NIMH) for efforts pertaining to homeless mentally ill persons. Since that time, NIMH has done the following to improve services for chronically mentally ill homeless persons:

- Ten research projects were funded in FYs 1982, 1983, and 1985 to examine the demographics, mental health status and service needs of the homeless mentally ill;
- Two meetings were held with the investigators of these research projects to discuss the implications of their findings for future research and service models; a final meeting is planned for July 1986;
- NIMH funded an analytic review of the literature on homelessness and its relationship to alcohol, drug abuse, and mental health disorders, as well as providing funds to an American Psychiatric Association Task Force to visit and describe model service programs for the homeless mentally ill;
- NIMH collaborated with the Office of the Deputy Undersecretary for Intergovernmental Affairs/DHHS in awarding a $150,000 contract to the U.S. Conference of Mayors to provide technical assistance to eight cities with high concentrations of the homeless mentally ill;
- Grant supplements, totalling $588,419 were awarded to six States with CSP grants to develop and demonstrate innovative approaches to service delivery for this population.

Major national leadership activities undertaken or planned by NIMH around the mentally ill homeless issue include:

- An Administrator's Roundtable on the ADM health problems of the homeless (1983);
- Funding to the National Association of State Mental Health Program Directors to convene State Commissioners to discuss the role of State Mental Health Authorities toward the homeless (1984);
- Collaboration with the American Public Health Association to convene a National Leadership Conference of major mental health organizations to discuss public policy regarding the homeless mentally ill (1985);
- NIMH expects to award a contract in 1985 for a national clearinghouse to develop, organize, and disseminate knowledge about the homeless mentally ill and their service needs; and
- Three meetings are planned for 1986 to focus on the role of nurses, on case management; and on homeless women.

Mr. Early. How many demonstration projects related to the homeless would be able to be supported by the CSP post sequestration funding level of $11.962 million? What would the average cost of these projects be?

Mr. Trachtenberg: At this level we expect to fund 6-7 demonstration projects related to the homeless mentally ill, at an average cost of $100,000 per project.

Mr. Early. How does this compare to the number of FY '85 demonstration projects and the average amount of the grants?

Mr. Trachtenberg. In FY 1985 we funded 6 supplements to existing CSP projects to support homeless mentally ill demonstration projects. The average amount of these supplements was almost $100,000.

CSP

Mr. Early. If the FY '86 post sequestration level for the CSP was maintained in FY '87, how would you allocate these funds?

Mr. Trachtenberg. We would allocate the $11,962,000 in FY 1987 CSP funds in the following manner:

Type:	Projects:	Amount:
Continuations		
Adult (includes ongoing State CSP projects, homeless mentally ill, and elderly demonstrations)	29	$ 3,960,000
Children (State strategy and community demonstrations)	28	$ 3,920,000
Research, Training, Technical assistance	5	$ 1,439,000
New		
Children (State strategy and community demonstrations)	10	$ 1,200,000
Adult (homeless mentally ill, young adult chronic patients, and elderly)	14	$ 1,443,000
TOTAL	86	$11,962,000

Mr. Early. Are there presently any demonstration project areas which you believe deserve a greater amount of federal support than what is currently available (using the post sequestration level as the currently available amount)?

Mr. Trachtenberg. Given the current fiscal position of the federal budget, we cannot assert that any area deserves more federal funds. However, should additional funds for this program become available, the following areas would be emphasized:

- Demonstrations of effective approaches to community-based programs for:
    - young adult long-term mentally ill persons;
    - the mentally ill in the criminal justice system;
    - the homeless mentally ill; and
    - persons with dual diagnoses such as mental illness and substance abuse or mental illness and mental retardation.
- Demonstrations of innovations in supportive housing for the long-term mentally ill.
- Demonstrations of improved strategic planning at the State level.
- Dissemination of consumer self-help alternatives.

Mr. Early. What evidence is there that states are incorporating the CSP philosophy to overcome barriers to care and services for persons with long-term mental illness?

Mr. Trachtenberg. The following is evidence that many States are beginning to incorporate CSP philosophy into their services for persons with long-term mental illness:

- Almost every State has designated the long-term mentally ill as the highest priority population for services.
- For every dollar of CSP grant funds received, States have been able to generate approximately $18.00 of other resources to benefit the population.
- Approximately half of the States involved in the CSP program have passed legislation or appropriated new funds on behalf of programs for the population.
- Approximately half of the States have begun to reorient ongoing programs or develop new programs with a more effective psychosocial rehabilitation approach.

- Approximately 45 programs were initiated with small amounts of startup funds from the CSP grants. These funds subsequently were replaced by State or local funds.

- Family groups (many begun as a result of CSP grant efforts) are becoming active in more States and are beginning to have a positive impact on the types and numbers of services being provided for the long-term mentally ill.

USE OF CLINICAL TRAINING FUNDS

Mr. Early. Assuming the proposed rescission for Clinical Training is rejected, and the program is maintained at the post sequestration level of $19.140 million, how would these funds be distributed?

Mr. Trachtenberg. The funds would be distributed as follows:

Priority Area	Allocation (in 000's)
Child Mental Health	$ 3,348
Geriatric Mental Health	2,868
Minority Training	3,348
Chronically Mentally Ill	3,348
Research and Development	867
Prevention	(325)
Other	(542)
Public Psychiatry	379
Paraprofessional Training	147
State Human Resources Development	3,878
Alcohol and Drug Abuse Identification	957
Total	$19,140

Mr. Early. What would be done to meet the growing need for expanded and improved clinical training in geriatrics?

Mr. Trachtenberg. The clinical training program in aging provides grants in the following areas:

-- Faculty Development Awards to develop a cadre of expert faculty in mental health and aging (career teachers). The faculty development award is designed to prepare teachers of geriatric mental health in clinical training centers where no local resource faculty currently exist.

-- Specialty training programs in geriatric mental health, with particular emphasis on postgraduate specialty training through fellowships. Postgraduate specialty training in academic geriatric mental health is designed to further develop training programs that are already active in the dissemination of mental health skills and knowledge by increasing the pool of potential faculty members through specialty training.

-- Geriatric training models to develop attention to mental health and aging the basic training of mental health care providers. Geriatric training models are designed to provide training experience to the nonspecialist in geriatrics and, at the same time, to stimulate the development of model materials and curricula for the incorporation of geriatric mental health skills and knowledge in the general training of the four core disciplines.

This approach was examined by the ad hoc committee convened to prepare the Report on Education and Training in Geriatrics and Gerontology prepared in response to a request contained in the Report on the FY 1984 budget by the House Committee on Appropriations. The ad hoc committee stated that "Clinical training activities in mental health and aging offer a model for a comprehensive and coherent approach to developing teachers and clinicians with pertinent knowledge and skills." (p. 2 of the report)

Mr. Early. What are your plans for continuing the joint training of mental health professional and vocational rehabilitation counselors?

Mr. Trachtenberg. This effort is part of the Clinical Training program which is proposed for rescission during the current fiscal year. In the event that the rescission is not adopted, we plan to place a high priority on preservice training to prepare mental health professionals to work with the chronically mentally ill. Within this priority area, emphasis is given to psychosocial rehabilitation, including vocational rehabilitation. We will give a high funding priority to those approved applications which include training on psychosocial rehabilitation approaches. In addition, the new Fiscal Year 1986 program announcement for research and development grants for improving mental health services training also gives a priority to the development of new curricula in the area of psychosocial rehabilitation. We hope to receive some grant applications under this program which will emphasize training models, related to vocational rehabilitation.

FY 1987 FUNDING LEVELS

Mr. Early. Will any significant research currently underway be halted or seriously delayed due to the FY 87 funding levels?

..... If so, provide a list of these along with a brief description and the amounts associated with each initiative.

Mr. Trachtenberg. The agency will not be required to delay or halt any significant research under the 1987 funding level. The proposed budget provides support for all continuation commitments relating to ongoing research. All research areas of priority emphasis will be funded at levels close to, or higher than, the dollar amounts spent in 1985.

Mr. Early. Will any significant new research initiatives or opportunities be lost or delayed due to the lack of funds in the FY 87 budget?

..... Please provide a list of these along with a brief description and the amounts associated with each.

Mr. Trachtenberg. All of the new research initiatives and opportunities that are considered to be significant will be funded, although some delays may be experienced. It is difficult at this time to determine the degree to which planned initiatives in these areas will be delayed. Although it is likely that some reductions from planned levels will be necessary, to the extent possible, planned new initiatives in these areas will be supported by drawing funds from other areas which, though important, are not of as high a priority.

New initiatives that will be affected include:

o Patient placement research that will determine the optimal length of stay in residential facilities, the relative efficacy of different therapies, the appropriateness of inpatient versus outpatient program settings for different types of patients, and the ideal mix of services ranging from detoxification to aftercare. Full implementation of this initiative would require an additional $2.1 million.

o Research into alcohol's effects on the immune system and the role of alcohol in the development of AIDS and other infectious diseases. Full implementation of this initiative would require $2.0 million. These opportunities have been identified in the last several months in response to work in this field.

o Research in genetics and molecular biology to learn the psychological and biochemical bases of genetic vulnerability to alcoholism and to identify genetic markers of susceptibility. Full implementation of this initiative within the intramural and extramural programs would require an additional $1.7 million.

o Lower priority new initiatives which will not be funded include expanding the Addiction Research Center where an additional $1.8 million would be needed to operate the full 32 bed clinical ward.

CLINICAL TRAINING

Mr. Hoyer. According to all accounts, including your own, the clinical training program in public psychiatry at the University of Maryland has been a tremendous success. Your budget request, however, provides zero funds for clinical training.

What alternative sources of funds are available to continue this vital work?

Mr. Trachtenberg. We anticipate that this, and other similar, successful psychiatry training programs can be supported by funds from universities themselves and from the State Mental Health Authorities.

IOM STUDY RECOMMENDATIONS

Mr. Hoyer. The Institute of Medicine of the National Academy of Sciences has reported that "the economic consequences of the disorders under the ADAMHA purview are comparable to those for heart disease and cancer". The Ad Hoc Group for Medical Research Funding, addressing the entirety of health research, has fully recognized and underscored the thrust of the IOM report in its recommendations to Congress. The President's budget, by contrast, flatly ignores the IOM study in proposing a reduction in federal support for ADAMHA research. Instead, of heeding the IOM recommendation for substantial increases in federal expenditures, this budget is based on an arbitrary policy of stabilizing total ADAMHA research projects at 1400, whereas the Agency's professional judgment calls for a least 1600 projects.

Has the Agency ignored the IOM study and recommendations?

Mr. Trachtenberg. We agree with the report's conclusion that the health consequences and economic costs of ADM disorders are immense and that there are many areas of exciting research opportunities which are not being full exploited given current funding levels. We also are aware of the current national fiscal situation and the hard choices which has to be made about scarce resources. In this situation it has not been possible to implement all of the IOM recommendations; however, we are attempting to be responsive. We have widely circulated the report within the agency and among our advisory groups. Recommendations in the IOM report concerning areas of scientific opportunity have been considered in developing program plans for areas of increased emphasis. For example, support has been provided for development of new technologies such as the PET scanner and NMR instrumentation.

STABILIZATION OF RESEARCH GRANTS

Mr. Hoyer. Dr. Edward Brandt, Chancellor of the University of Maryland at Baltimore and former Assistant Secretary for Health in the Reagan Administration, has written that "some stability should be explored to avoid sudden ups and downs which interfere with the ability of the scientific community to be responsive to national needs". Are you aware this new "stabilization" initiative necessarily restricts the number of new grants to a level of 448, compared to the 550 we provided for in FY 86 appropriation act? This is a 20% reduction in the support of new young investigators who are the lifeblood of the biomedical and behavioral research enterprise.

Mr. Trachtenberg. While the number of new grants will be less this year, it should be noted that the total number of grants at which we are now stabilizing, i.e., 1400, is the highest level in recent years. We believe that maintaining support at this total level will continue to supply funding to a reasonable number of competent researchers to the ADM fold, including new investigators.

RESEARCH CENTERS

Mr. Hoyer. The budget proposes to fund only 1 new NIMH Research Center in FY 1986 and 0 in FY 1987, despite the fact that Centers are an extremely important component of the research portofolio that allow several investigators from different disciplines to examine complex disorders in a team setting. Why does the budget propose no new centers in FY 1987 and reduce new NIMH Centers from 3 to 1 under the FY 1986 sequester?

Mr. Trachtenberg. First, let us consider the 1986 budget. There is in fact no reduction below the three new centers originally planned. One of the three - for the study of schizophrenia - is already funded. The other two are for research on AIDS. The two AIDS centers were not reflected in the 1986 revised column of ADAMHA's Congressional justification in order to make the base year comparable with 1987, at which time we are proposing to transfer all AIDS project funding to the Office of the Assistant Secretary for Health. We will in fact be supporting the two AIDS centers this year.

In 1987, no new centers are proposed; however, if we receive renewal applications of a sufficiently high priority score, we will do whatever is necessary to maintain the 1986 level of 23 centers. Within available resources, we wanted to insure that all of our investigator-initiated research was maintained at a viable level. It would not have been possible to do this and still support a new center.

FISCAL YEAR 1987

Volume V

Justification of Appropriation Estimates for Committee on Appropriations

Alcohol, Drug Abuse and Mental Health Administration

DEPARTMENT OF HEALTH AND HUMAN SERVICES

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

Alcohol, Drug Abuse, and Mental Health

Fiscal Year 1987 Budget ..... Page

Appropriation language and explanation of language changes 1

Amounts available for obligation 2

Summary by mechanism 3

Summary of changes 4

Budget authority by activity 6

Budget authority by object 8

Average grade and salary 8

Significant items in House and Senate Appropriation Committee reports 10

Authorizing legislation 19

Appropriations history 21

Tables of estimates and appropriations 22

Justification:
- A. General statement 22
- B. Program accomplishments 25
- C. Activities
  - 1. Mental health 28
  - 2. Drug abuse 68
  - 3. Alcoholism 102
  - 4. Buildings and facilities 131
  - 5. Program management 132
  - 6. Block grant 134
- D. Detail of permanent positions 137
- E. Estimates for consulting services 138
- F. Estimates for related services 140

Alcohol, Drug Abuse, and Mental Health

For carrying out the Public Health Service Act with respect to mental health, drug abuse, alcohol abuse, and alcoholism, [$958,860,000] *$892,240,000* of which [$100,000] *$600,000* for [design, modernization, and improvement] *renovation* of government owned or leased intramural research facilities shall remain available until expended [: *Provided,* That in addition to amounts provided herein, *$10,000,000* shall be available for carrying out activities for protection and advocacy for mentally ill persons, to become available upon enactment of authorizing legislation.]. 1/ *(Department of Health and Human Services Appropriation Act, 1986.)*

1/ This language appropriating funds for protection and advocacy activities will not be required in 1987 since appropriations for this program are not requested. Furthermore, if authorization is provided the language is not necessary.

2

Alcohol, Drug Abuse, and Mental Health

Amounts Available for Obligation

	1985	1986	1987
Appropriation:			
Annual...	$925,121,000	$968,860,000	$892,240,000
Sequester Order.........		-41,661,000	---
Proposed Rescission.....	---	-39,718,000	---
Subtotal, adjusted appropriation..........	925,121,000	887,481,000	892,240,000
Comparative transfers to:			
National Institutes of Health for Management Fund....................	-2,134,000	---	---
Office of the Assistant Secretary for Health for standard level user charge (rent)..........	-25,000	---	---
Office of the Assistant Secretary of Health for AIDS research..........	-2,578,000	-12,158,000	---
Subtotal, adjusted budget authority.......	920,384,000	875,323,000	892,240,000
Unobligated balance, start of year...........	1,592,000	1,220,000	---
Unobligated balance, end of year.............	-1,220,000	---	---
Unobligated balance, lapsing 1/...............	-1,574,000	-1,092,000	---
Total obligations 2/..	$919,182,000	$875,451,000	$892,240,000

1/ Includes the following amounts required to be withheld by section 515 of the Treasury-Postal Services Appropriation Acts: 1985 - $1,495,000; 1986 - $1,092,000.

2/ Excludes the following amounts for reimbursable activities carried out by this account: 1985- $5,383,242; 1986 - $2,864,000; 1987 - $16,798,000.

Alcohol, Drug Abuse, and Mental Health Administration
Summary by Mechanism

	1985 Actual*		1986 Appropriation		FY 1986 Revised **		FY 1987	
	No.	Amount	No.	Amount	No.	Amount	No.	Amount
Research:								
Research Project Grants:								
Noncompeting.........	763	$105,931,000	903	$131,070,000	890	$128,756,000	930	$137,332,000
Supplements	(46)	1,501,000	(90)	4,401,000	(71)	2,982,000	(62)	2,478,000
New..................	329	40,430,000	297	42,489,000	291	32,906,000	250	30,406,000
Competing............	214	29,586,000	208	30,321,000	205	30,834,000	198	28,874,000
Subtotal...........	1,306	177,448,000	1,408	208,281,000	1,386	195,478,000	1,378	199,090,000
(With AIDS reimb.).....	(1,323)	(179,685,000)			(1,408)	(199,325,000)	(1,400)	(202,360,000)
Other Research:								
Research Centers.....	35	22,162,000	38	23,885,000	36	22,593,000	31	19,707,000
RSDA.................	212	11,867,000	230	12,918,000	211	11,846,000	187	10,493,000
SBIR.................	36	2,396,000	36	3,401,000	35	3,247,000	30	3,132,000
Small Grants.........	87	1,831,000	81	1,817,000	74	1,662,000	36	811,000
Cooperative Agreement	27	6,974,000	24	6,085,000	26	5,850,000	11	2,867,000
Contracts............	50	11,511,000	63	15,199,000	41	9,694,000	33	9,001,000
Subtotal, Other Mech.	477	56,741,000	472	63,305,000	421	54,892,000	328	46,011,000
Intramural Research....	—	69,606,000	—	73,414,000	—	69,683,000	—	73,812,000
Total, Research	1,753	303,795,000	1,880	345,000,000	1,807	320,053,000	1,706	318,913,000
Planning & Demonstrations	80	12,998,000	—	12,500,000	—	954,000	—	—
Protection & Advocacy....	—	—	—	10,000,000	—	—	—	—
Training:								
Research Training:								
Institutional Awards.	172	18,057,000	163	17,684,000	162	16,942,000	147	15,728,000
Individual Awards....	165	2,941,000	194	3,316,000	171	3,155,000	147	2,801,000
Subtotal, Res. Trng	337	20,998,000	357	21,000,000	333	20,097,000	294	18,529,000
Clinical Training......	469	21,998,000	347	20,000,000	—	—	—	—
Total, Training	806	42,996,000	704	41,000,000	333	20,097,000	294	18,529,000
Direct Operations........	—	61,401,000	—	62,640,000	—	56,809,000	—	56,808,000
Subtotal, ADAMHA.....	2,639	421,190,000	2,584	471,140,000	2,140	397,914,000	2,000	394,250,000
Program Management.......	—	7,620,000	—	7,620,000	—	7,292,000	—	7,390,000
Buildings & Facilities...	—	372,000	—	100,000	—	1,316,000	—	600,000
Block Grants.............	—	490,000,000	—	490,000,000	—	468,930,000	—	490,000,000
Total, ADAMHA.......	2,639	919,182,000	2,584	968,860,000	2,140	875,451,000	2,000	892,240,000

* This column excludes $4,737,000, of which $2,578,000 is a reduction for the comparable transfer of Priority Disease Control and Research Projects (AIDS) to the Office of the Assistant Secretary for Health; $25,000 which is a comparable reduction for the Office of the Assistant Secretary of Health SLUC payments; and $2,134,000 to NIH for Management Fund costs.

** This column excludes $94,629,000, of which $12,158,000 is for the comparable transfer of Priority Disease Control and Research Projects (AIDS) to the Office of the Assistant Secretary; $1,092,000 which is required to be withheld by Section 515 of the Treasury, Postal Service, and General Government Appropriations Act, 1986; $39,718,000 which is proposed for rescission; and $41,661,000 which is required to be reduced pursuant to the Balanced Budget and Emergency Deficit Control Act of 1985, P.L. 99-177.

4

Alcohol, Drug Abuse, and Mental Health
Summary of Changes

1986 Appropriation	$968,860,000
1986 Sequester order	-41,661,000
1986 Proposed rescission	-39,718,000
1986 Comparable reduction for AIDS	-12,158,000
1986 Unobligated balance, lapsing	-1,092,000
Total estimated budget authority	874,231,000
1987 Request	892,240,000
Net change	+$18,009,000

Increases:	1986 Base	Change from Base
Built-in:		
1. Within grade increases	$64,576,000	+$1,421,000
2. Increased FTS costs	574,000	+24,000
3. Increased payments to Federal Employee Compensation Fund	1,719,000	+40,000
4. Increased Standard Level User charges	2,396,000	+93,000
5. Increased Social Security benefits	1,175,000	+166,000
6. Increased cost for non-pay items	38,493,000	+1,617,000
7. Increased NIH Management Fund costs	19,907,000	+1,285,000
8. Increased NIH Service and Supply Fund	3,129,000	+188,000
9. Increased support costs at Saint Elizabeths Hospital research facility	3,734,000	+157,000
10. Annualization of Clinical Services	---	+191,000
Program:		
1. General Mental Health:		
a. Extramural Research - support for continuation costs of grants	145,321,000	+719,000
b. Intramural Research - maintenance of current program level	55,124,000	+798,000
2. Drug Abuse:		
a. Extramural Research - support for continuation costs of grants	59,274,000	+2,761,000
b. Intramural Research - maintenance of current program level	5,962,000	+268,000
c. Direct Operations - maintenance of current program level	13,816,000	+234,000
3. Alcoholism:		
a. Extramural Research - support for continuation costs of grants	45,775,000	+940,000
4. Buildings & Facilities - maintenance of intramural research facilities and renovations at the Flow Laboratory Building	96,000	+504,000
5. Block Grants - maintenance of current program level	468,930,000	+21,070,000
Subtotal	---	+32,476,000

Alcohol, Drug Abuse, and Mental Health
Summary of Changes - Continued

Decreases:	1986 Base	Change from Base
Built-in:		
1. Reduction in PHS Service and Supply Fund....................................	$3,934,000	-$71,000
2. Reduction in standard level user charges...	2,396,000	-177,000
Program:		
1. General Mental Health:		
a. Extramural Research - reduction of new awards in Other Mechanisms........	145,321,000	-8,643,000
b. Planning and Demonstrations - reduction to complete phaseout of program...................	954,000	-954,000
c. Research Training - reduction of support for 65 trainees...............	17,225,000	-1,378,000
d. Direct Operations - savings in reducing administrative overhead costs, and reduction of contract costs.......	31,836,000	-977,000
2. Drug Abuse:		
a. Extramural Research - reduction of new awards in Other Mechanisms.............	59,274,000	-1,046,000
b. Research Training - reduction of support for 9 fellowships..............	1,436,000	-81,000
c. Direct Operations - savings in administrative overhead costs..........	13,816,000	-247,000
3. Alcoholism:		
a. Intramural Research - reduction of equipment purchases.....................	8,597,000	-155,000
b. Research Training - reduction of support for 3 trainees.................	1,436,000	-109,000
c. Direct Operations - savings in reducing administrative overhead costs, and reduction of contract costs........	11,157,000	-588,000
4. Program Management - reductions in contract support and program-related conferences, and savings in reducing travel, equipment purchases, and staff training.........................	7,292,000	-41,000
Subtotal............................	---	-14,467,000
Net change..........................	---	+$18,009,000

Budget Authority by Activity
(Dollars in thousands)

	1986 Appropriation	1986 Available after Sequestering	1986 Revised		1987	
	Amount	Amount	FTEs	Amount	FTEs	Amount
1. Mental Health						
a. Research:						
(1) Extramural...	$156,399	$149,674	---	$145,321	---	$137,397
(2) Intramural...	57,601	55,124	526	55,124	526	57,493
Subtotal, Res	214,000	204,798	526	200,445	526	194,890
b. Planning & Demon.	12,500	11,962		954		---
c. Prot. & Advoc....	10,000	9,570		---		---
d. Training:						
(1) Clinical.....	20,000	19,140	---	---	---	---
(2) Research.....	18,000	17,225	---	17,225	---	15,847
Subt. Trng...	38,000	36,365	---	17,225	---	15,847
e. Direct Operations	34,675	33,184	364	31,836	364	31,749
Subtotal, MH.	309,175	295,879	890	250,460	890	242,486
2. Drug Abuse						
a. Research:						
(1) Extramural...	67,170	64,281	---	59,274	---	60,989
(2) Intramural...	6,830	6,536	85	5,962	85	6,416
Subtotal, Res	74,000	70,817	85	65,236	85	67,405
b. Research Training	1,500	1,436	---	1,436	---	1,355
c. Direct Operations	16,307	15,606	175	13,816	175	14,1
Subtotal, DA.	91,807	87,859	260	80,488	260	82,94
3. Alcoholism						
a. Research:						
(1) Extramural...	48,017	45,953	---	45,775	---	46,715
(2) Intramural...	8,983	8,597	92	8,597	92	9,903
Subtotal, Res	57,000	54,550	92	54,372	92	56,618
b. Research Training	1,500	1,436	---	1,436	---	1,327
c. Direct Operations	11,658	11,157	110	11,157	110	10,876
Subtotal, AA.	70,158	67,143	202	66,965	202	68,821
4. Program Management.	7,620	7,292	149	7,292	149	7,390
5. Bldgs. & Facil.....	1,320	1,316	---	1,316	---	600
Subtotal, ADAMHA.	480,080	459,489	1,501	406,521	1,501	402,240
6. Block Grant........	490,000	468,930	---	468,930	---	490,000
Total Obligations.....	970,080	928,419	1,501	875,451	1,501	892,240
Unobligated balance, start of year........	-1,220	-1,220		-1,220		---
Unobligated balance, lapsing..............	---	---		1,092		---
Unobligated balance, transferred..........	---	---		---		---
Unobligated balance, end of year..........	---	---		---		
Total Budget Authority	$968,860	$927,199	1,501	$875,323	1,501	$892,

NOTES

All footnotes refer to the 1986 Revised column:

1a(1). Excludes $650,000 which is required to be withheld by the Treasury, Postal Service, and General Government Appropriations Act, 1986; and $3,703,000, which is a comparable reduction for the transfer of Priority Disease Control and Research Projects (AIDS) to the Office of the Assistant Secretary for Health.

1b. Reflects a proposed rescission of $11,008 for the Community Support Program.

1c. Reflects a proposed rescission of $9,570,000 for the Protection & Advocacy Program.

1d(1). Reflects a proposed rescission of $19,140,000 for the Clinical Training Program.

1e. Excludes $1,348,000 which is a comparable reduction for the transfer of Priority Disease Control and Research Projects (AIDS) to the Office of the Assistant Secretary for Health.

2a(1). Excludes $264,000 which is required to be withheld by the Treasury, Postal Service, and General Government Appropriations Act, 1986; and $4,743,000, which is a comparable reduction for the transfer of Priority Disease Control and Research Projects (AIDS) to the Office of the Assistant Secretary for Health.

2a(2). Excludes $574,000 which is a comparable reduction for the transfer of Priority Disease Control and Research Projects (AIDS) to the Office of the Assistant Secretary for Health.

2c. Excludes $1,790,000 which is a comparable reduction for the transfer of Priority Disease Control and Research Projects (AIDS funding) to the Office of the Assistant Secretary for Health.

3a(1). Excludes $178,000 which is required to be withheld by the Treasury, Postal Service, and General Government Appropriations Act, 1986.

Alcohol, Drug Abuse and Mental Health Administration
Budget Authority by Object

	1985	1986	1987
Total number of full-time permanent positions.................	1,044	1,004	1,004
Total compensable workyears:			
Full-time equivalent employment.....	1,612	1,558	1,558
Full-time equivalent of overtime and holiday hours..................	11	11	11
Average ES salary.....................	$68,252	$68,400	$68,500
Average GS grade......................	10.12	10.12	10.12
Average GS salary.....................	$33,548	$34,286	$35,040
Average salary, grades established by PHS Act of 1955 (42 USC 207).....	34,011	34,759	35,524
Average salary of ungraded positions.	19,240	19,663	20,096
Personnel compensation:			
Full-time permanent.................	$40,067,000	$41,441,000	$42,414,000
Other than full-time permanent......	13,250,000	13,668,000	13,856,000
Other personnel compensation........	1,640,000	1,677,000	1,685,000
Special personnel services payments.	1,295,000	1,357,000	1,312,000
Total personnel compensation....	56,252,000	58,143,000	59,267,000
Personnel benefits....................	7,342,000	7,613,000	7,875,000
Benefits for former personnel.........	41,000	---	---
Travel and transportation of persons..	1,610,000	1,563,000	1,681,000
Transportation of things..............	152,000	160,000	162,000

Budget Authority by Object

	1985	1986	1987
Rent, communications and utilities:			
Standard level user charges..........	2,371,000	2,396,000	2,312,000
Rental payments to others............	34,000	36,000	36,000
Communications, utilities, and miscellaneous charges...............	2,734,000	2,969,000	2,936,000
Printing and reproduction.............	1,647,000	1,388,000	1,592,000
Other services........................	47,101,000	44,063,000	43,884,000
Project contracts....................	20,799,000	15,375,000	16,475,000
Supplies and materials................	6,018,000	5,437,000	5,642,000
Equipment.............................	6,484,000	5,473,000	5,286,000
Lands and structures..................	---	---	---
Grants, subsidies and contributions........................	766,597,000	730,835,000	745,092,000
Subtotal, obligations..............	919,182,000	875,451,000	892,240,000
Unobligated balance, start of year.....	-1,592,000	-1,220,000	---
Unobligated balance, lapsing...........	+1,574,000	+1,092,000	---
Unobligated balance, end of year.......	+1,220,000	---	---
Subtotal...........................	920,384,000	875,323,000	892,240,000
Comparability adjustments..............	+4,737,000	+12,158,000	---
Appropriation......................	$925,121,000	$887,481,000[1/]	$892,240,000

[1/] Reflects a reduction of $41,661,000 pursuant to the Balanced Budget and Emergency Deficit Control Act of 1985, P.L. 99-177: and a proposed rescission of $39,718,000.

10

Significant Items in House and Senate Appropriation Committee Reports

Item	Action Taken or to be Taken
1986 House Report No. 99-289	
Teen Suicide	
1. Among the problems being studied by NIMH, none is more compelling or more urgent than teen suicide. Recent studies indicate an almost threefold increase in the suicide rate for 15-24 year olds to a level of 12.5 per 100,000. Between 1970 and 1978 at least 39,000 young adults took their own lives. The Institute is to be commended for its efforts in this area, in particular for its collaborative program with the Centers for Disease Control. Much more, however, needs to be done and the Committee urges the Director to expand research into the cause and prevention of suicide among this age group. (page 83)	As a result of the recent reorganization of NIMH, we have extended the range of programs actively supporting research on suicide as well as addressing methodological and conceptual issues in the field, enhancing the prospects for more targeted and effective research. An NIMH staff member has been appointed Chairman of the Secretary's Task Force on Youth Suicide, and has a direct involvement in promoting research and interventions on suicide. We have declared youth suicide as a program priority area in order to encourage more research on the psychobiological and social etiological factors that may be implicated in suicide. In addition, we are researching ways to effectively prevent suicide, including the identification of risk factors and early diagnosis and treatment of depression in youth. As part of the Task Force, work groups have been established which address risk factors, prevention, and treatment. The final report will provide guidance and direction to the field on the research still needed as well as on appropriate interventions and treatments.

Item	Action Taken or to be Taken
1986 House Report No. 99-289	
Joint Training	
2. In the FY 1985 report, the Committee directed NIMH to fund projects which would provide joint in-service training for mental health professionals and vocational rehabilitation counselors working with chronically mentally ill adults in the community. The Committee is disturbed that this directive was never followed. The Committee reiterates the request that NIMH allocate at least $350,000 from the clinical training budget to this program. It is further expected that this will be accomplished without the need for further statutory language. (page 84)	In FY 1985 NIMH did provide, through an interagency agreement with the Rehabilitation Services Administration, $257,000 for joint in-service training for mental health professionals and vocational rehabilitation counselors working with the chronically mentally ill. The Clinical Training Program is proposed for rescission in 1986 since it is believed that, after our 30 years of federal support, the nation now has adequate capacity to sustain these programs as necessary on a local level.
Minority Programs	
3. Over the past several years, the Committee has approved substantial budget increases in ADAMHA research and research training activities. The Committee has also stressed the serious problems of underrepresentation of minority mental health professionals and the need for more research on the mental health problems facing minorities. The Committee would like to indicate in the strongest terms that these programs, along with the Minority Fellowship Program should be accorded a very high priority for additional funding in FY 1986 not only from NIMH, but also NIAAA and NIDA. (page 87)	Each institute plans to continue to stimulate the submission of high-quality research grant applications from minority scientists, as well as non-minority, scientists to study minority research issues. The recent reorganization at NIMH has, for the first time, combined the programs for minorities in the Minority Research Resources Branch of the Division of Biometry and Applied Sciences. This will permit a much more coordinated operation where the separate components can be viewed in perspective, students can be tracked through the different support levels, and undergraduate trainees steered to the graduate support mechanisms. Thus NIMH expects to more closely allocate resources to areas of need within these programs under the research training budget.

Item	Action Taken or to be Taken
1986 House Report No. 99-289	Both NIDA and NIAAA will assist in the planning and conducting of research symposia aimed at identifying key minority issues and encouraging the submission of grant applications through the regular researh grant announcements.
1986 Senate Report No. 99-151 Mental Health Problems of Immigrants and Refugees	
1. The Committee urges the Department to encourage the various States to ensure that the mental health problems of immigrants and refugees are addressed by the resources provided by the ADAMHA block grant. (pages 115-116)	ADAMHA has no authority under the current legislation to direct States to allocate block grant funds to these two areas. Funds provided to the States under the block grant program do not specifically identify mental health problems of immigrants and refugees as a required service. Instead, the States are required under law to accomplish an assessment of needs for mental health services. It is anticipated that if a State's assessment of need determines the mental health problems of immigrants and refugees to be of a sufficently critical nature, then the ADM block grant funds would, along with other sources of funds, be directed toward the provision of services to those areas.
Community Support Program	
2. The Committee expects that, within recommended funding for the mental health community support program, increased efforts will be targeted to special populations, such as children and adolescents, the elderly, and the homeless mentally ill. (page 116)	Since its inception in 1977 about $58 million has been spent to demonstrate the efficacy of these programs. The rescission reflects the belief that the original demonstration period is now complete and that States may continue these programs, to the extent they are deemed beneficial, with block grants or other local funds.

Item	Action Taken or to be Taken
1986 Senate Report No. 99-151	
Psychotherapy Research	
3. The Committee is especially concerned that research continue to be supported by NIMH in the area of psychotherapy research, including evaluating various treatment approaches. (page 117)	The NIMH has been supporting psychosocial treatment research since its inception in the late 1940's. In the course of its history, NIMH has awarded well over 400 grants to investigate a wide variety of psychotherapeutic approaches to mental and emotional disorders. In FY 1985, the NIMH awarded just under $6 million in grant funds for studies of psychosocial treatments. Under the recent reorganization of the NIMH, psychotherapy research will continue on a variety of mental disorders, including schizophrenia, affective and anxiety disorders, childhood disorders, etc. In addition, a coordinator for psychosocial treatment research has been named who will oversee psychotherapy research with the NIMH. In FY 1986, workshops are planned on family therapy, the integration of the psychotherapies, research on psychotherapy process, and research on psychosocial treatment of adolescent depression. We anticipate that these workshops will stimulate psychotherapy research of high quality.
Appointment of Professional Nurses to Advisory Committees	
4. The Committee continues to be concerned that the NIMH is not giving sufficient priority to appointing professional nurses to its advisory committees and, further, that research and training applications from schools of nursing are not receiving appropriate levels of funding. This is a concern which the Committee has raised for the past several years. (page 118)	The Director, NIMH, is appointing a task force to examine mechanisms for increasing participation of nurses in NIMH extramural research activities. NIMH is developing a roster of nurse researchers for use in developing nominations for its initial review committees. The National Advisory Mental Health Council presently has, and has had for the last six years, a nurse member.

Item	Action Taken or to be Taken
1986 Senate Report No. 99-151 Appointment of Professional Nurses to Advisory Committees 4.	The Aging Subcommittee of the Life Course Research Review Committee has two nurse members. All special review committees organized to review applications for clinical training support for fiscal year 1985 had nurse members. Nurses and schools of nursing submit few applications for research support reflecting, at least in large part, the small number of nurses trained to conduct mental health research. Two research mechanisms are being used to encourage development of nurse researchers--the Geriatric Mental Health Academic Award (limited to psychiatric nursing and psychiatry) and the Clinical Investigator Award (focused on the clinical disciplines). In addition, training of minority nurse researchers is supported through an NRSA training grant to the American Nurses Association.
Minority Fellowship Program 5. The Committee has continually urged NIMH to provide increasing support for the minority fellowship program. This initiative has demonstrated an excellent record in increasing the number of minority professionls in all disciplines. Accordingly, the committee again strongly urges NIMH to increase the allocation of funds to this particular initiative this fiscal year. (page 119)	The Institute will make every effort to allocate sufficient research training funds to this program during the current fiscal year. However, Federal support for this program in 1986 will be somewhat reduced, due to the proposed rescission of clinical training funds in 1986. The Clinical Training Program is proposed for rescission in 1986 since it is believed that, after our 30 years of federal support, the nation now has adequate capacity to sustain these programs as necessary on a local level.

Item	Action Taken or to be Taken
1986 Senate Report No. 99-151	
Priority for State Manpower Training Programs	
6. Consistent with the importance to the States of the State Manpower Development Program to their training efforts, the Committee directs NIMH to expand the level of support for this program in fiscal year 1986. (page 119)	The clinical training program, of which State Manpower Development is a part, is proposed for rescission during the current fiscal year. The Clinical Training Program is proposed for rescission in 1986 since it is believed that, after our 30 years of federal support, the nation now has adequate capacity to sustain these programs as necessary on a local level.
Mental Health Needs of the Homeless	
7. The Committee is impressed by the American Psychiatric Association's report on the mental health needs of the homeless and urges NIMH to develop projects for this population. (page 120)	The Community Support Program, which supports the bulk of the Institute's programs relating to the homeless, is proposed for rescission during the current fiscal year. Since its inception in 1977 about $58 million has been spent to demonstrate the efficacy of these programs. The rescission reflects the belief that the original demonstration period is now complete and that States may continue these programs, to the extent they are deemed benefical, with block grant or other local funds.

Item	Action Taken or to be Taken
1986 Senate Report No. 99-151	
Training of Mental Health Professional to Provide Psychosocial Rehabilitation Services	
8. Within the funds provided, the Committee expects that NIMH will initiate a new program of training of mental health professionals to treat and provide psychosocial rehabilitation services to seriously and chronically mentally ill adults in community settings. (page 120)	The Institute's clinical training program is proposed for rescission during the current fiscal year.
Synthetic Narcotics	
9. The Committee is concerned about the production and use of synthetic narcotics which can be substantially more potent than the illegal narcotics presently available and to which over 100 deaths, and numerous cases of long-term neurodegenerative conditions have been attributed. Therefore, NIDA is directed to include information about the hazards of synthetic narcotic drugs (for example, fentanyl and meperidine	NIDA has developed and disseminated several publications on the hazards of "designer" or synthetic drugs. These include: a news capsule explaining the hazards of MDMA which was circulated to the press and to State agency planners and directors; Clinical Research Notes containing information about the effects and hazards of MDMA which was disseminated to treatment service providers, prevention

Item	Action Taken or to be Taken
1986 Senate Report No. 99-151	
analogs) and their pernicious contaminants (for example, MPTP) in its presentation program including efforts to educate the public through the use of the American mass media and our young people through our educational system. (page 122)	personnel and public officials involved in the planning of drug abuse services; and a newsletter containing information on synthetic drugs which was disseminated to policy and program personnel associated with the mental health and alcohol abuse fields as well as drug abuse treatment and prevention providers. NIDA will continue to monitor developments in the distribution and abuse of synthetic drugs and distribute information on their effects and hazards, along with information on ways of preventing and treating their use, to drug abuse prevention and service providers.
Native Hawaiians	
10. The Committee reiterates its directive that NIAAA give special attention to the pressing needs of native Hawaiians. These are native American Peoples and, as such, there is a special Federal responsibility involved. (pages 122-123)	NIAAA continues to seek applications for research projects that will examine biological and cultural factors which may be of importance in the development, expression, treatment, and prevention of alcoholism in ethnic populations, including native Hawaiians, Pacific Islanders and Oriental ethnic groups which comprise a significant percentage of the population in Hawaii and the Pacific Islands. One new grant was awarded through the Minority Scholar program which will enable the hiring of a scholar who will provide direction and expertise in identifying research needs, designing and developing research projects, and conducting research on alcohol use and abuse by Americans of Pacific Islander/Asian heritage. Staff from the Institute will be working with this grantee to maximize research in this important area and will continue to provide assistance and encouragement to other investigators who wish to study how alcohol

Item	Action Taken or to be Taken
1986 Senate Report No. 99-151	
	uniquely affects minority populations including those who live in Hawaii. In September 1985 the Institute supported a minority research conference attended by a number of persons from Hawaii. At that time, the problems of this population and other ethnic/racial minorities were addressed in detail and recommendations for further research were made. The proceedings of this conference will be available in the Spring of 1986.
Expanded Research Efforts	
11. The Committee directs ADAMHA to expand its efforts on prevention, individual and group behavior change, psychological implications of AIDS and HTLV-III infections, and improved treatment procedures. (page 115)	ADAMHA will greatly expand its Acquired Immunodeficiency Syndrome (AIDS) research and AIDS activities in both 1986 and 1987. ADAMHA has recently released an agency announcement soliciting applications for investigator initiated AIDS research for all three ADAMHA institutes. A similar announcement soliciting research centers by NIMH and NIDA will be released shortly. NIAAA has held a conference on the immunosuppressive aspects of alcohol focused on a review of available research and recommendations for future research. ADAMHA is in the planning stage for a conference on mental health and substance abuse cofactors for AIDS. Agency personnel have organized special AIDS symposiums for both the American College of Neuropsychopharmacology and the American Psychiatric Association meetings. Two special issues of Psychiatry Annals on AIDS have been edited and written by ADAMHA personnel. ADAMHA also plans to initiate the following AIDS activities: 1) new project awards to support research on AIDS;

Item	Action Taken or to be Taken
1986 Senate Report No. 99-151	2) participation in the NIH Concensus Conference on the impact of HTLV-III antibody screening, 3) research workshops to disseminate and synthesize AIDS research information; 4) technical assistance to health care providers and researchers on methods and procedures to care for AIDS patients; and 5) development of monographs, brochures, and education materials on AIDS.
1986 House Conference Report No. 99-402 Prevention Activities 1. The conferees continue to be impressed by the long-term importance of prevention activities to the well being of the nation and accordingly encourage the National Institute of Mental Health to continue to give prevention a high priority under its clinical training and research authorities. (page 20)	In 1986, NIMH is increasing its support for prevention research by 11 percent, compared to an increase of 5.5 percent in the total budget after sequestering. Prevention research will focus on high-risk infants, children, youth, minority groups, and other at-risk populations. The clinical training program is proposed for rescission in 1986; therefore, support for prevention programs in this area will be discontinued.

Item	Action Taken or to be Taken
1986 House Conference Report No. 99-402 Clinical Research Centers for the Elderly	
2. The conferees are pleased by the efforts of the clinical research centers for the elderly, and within the increased funds provided for NIMH research, encourage an expansion of this activity. (page 20)	Support of research centers for the elderly will be expanded in 1986. Although neither the budget request nor the appropriation provided for additional centers beyond the five now supported, increased funding provided by the Congress has made it possible to support the existing aging centers at levels considerably higher than projected under the original President's budget. These centers will now be funded at levels close to their originally approved budgets, whereas previously they would have had to take reductions of 15 percent.

Alcohol, Drug Abuse, and Mental Health

Authorizing Legislation

	1986 Amount Authorized	1986 Revised	1987 Amount Authorized	1987
1. General Mental Health:				
a. Research:				
General-Section 301 of the Public Health Service Act (PHSA)	Indefinite	$200,445,000	Indefinite	$194,890,000
b. Planning & Demonstrations:				
State Planning - PHSA Section 504	Indefinite	---	Indefinite	---
Community Support - PHSA Section 506	$20,000,000	954,000	$20,000,000	---
c. Protection and Advocacy 1/	---	---	---	---
d. Training:				
Clinical-PHSA Section 303	Indefinite	---	Indefinite	---
Research-PHSA Section 472 2/	244,000,000	17,225,000	260,000,000	15,847,000
e. Direct Operations:				
PHSA Section 301	Indefinite	31,836,000	Indefinite	31,749,000
2. Drug Abuse:				
a. Research:				
PHSA Section 301	Indefinite	---	Indefinite	67,405,000
PHSA Section 517	74,000,000	65,236,000	Expired	---
b. Training:				
Research-PHSA Section 472 2/	(244,000,000)	1,436,000	(260,000,000)	1,355,000
c. Direct Operations:				
PHSA Section 301	Indefinite	13,816,000	Indefinite	14,183,000
3. Alcohol:				
a. Research:				
PHSA Section 301	Indefinite	---	Indefinite	56,618,000
PHSA Section 513	61,000,000	54,372,000	Expired	---
b. Training:				
Research-PHSA Section 472 2/	(244,000,000)	1,436,000	(260,000,000)	1,327,000
c. Direct Operations:				
PHSA Section 301	Indefinite	11,157,000	Indefinite	10,876,000
4. Buildings and Facilities:				
PHSA Section 301	Indefinite	96,000	Indefinite	600,000

Alcohol, Drug Abuse, and Mental Health

Authorizing Legislation - Continued

	1986 Amount Authorized	1986 Revised	1987 Amount Authorized	1987
5. Program Management:				
PHSA Section 301.........	Indefinite	7,292,000	Indefinite	7,390,000
6. Block Grant:				
PHSA Section 1911........	545,000,000	468,930,000	576,000,000	490,000,000
Total appropriation..	---	874,231,000	---	892,240,000
Total appropriation against definite authorizations.......	$944,000,000	$609,590,000	$856,000,000	$508,529,000

1/ Congress appropriated $10,000,000 pending enactment of authorizing legislation. This amount is proposed for rescission in 1986.

2/ The authorizations of $244,000,000 for 1986 and $260,000,000 for 1987 are also the authority cited for research training for NIH. The total requested against this authorization is $20,097,000 in 1986 and $18,529,000 in 1987.

ALCOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION
Alcohol, Drug Abuse and Mental Health

Appropriations History

Year	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
1978	877,656,000	931,020,000	947,745,000	941,700,000
1979	1,002,871,000	730,022,000	752,022,000	1,025,403,000
1980	1,114,610,000	630,148,000	630,148,000	1,019,866,000
1981	1,164,696,000	1,049,077,000	1,049,077,000	934,083,000
1982	344,026,000	839,726,000	781,367,000	761,007,000
1983	305,177,000	798,506,000	812,831,000	809,344,000
1984	357,826,000	799,202,000	835,581,000	848,015,000
1985	372,655,000	405,318,000 1/	930,232,000	925,121,000
1986	886,194,000	903,637,000	995,539,000	968,860,000
1986 Sequester	-41,661,000			
1986 Proposed Rescission	-39,716,000			
1987	892,240,000			

1/ House did not consider the research training and block grant programs, as they lacked authorizing legislation.

Justification

Alcohol, Drug Abuse, and Mental Health Administration

	1986 Appropriation	1986 Available after Sequestering	1986 Revised Estimate 1/	1987	Increase or Decrease
Mental Health...	$309,175,000	$295,879,000	$250,460,000	$242,486,000	-$7,974,000
FTEs........			890	890	---
Drug Abuse......	91,807,000	87,859,000	80,488,000	82,943,000	+2,455,000
FTEs........			260	260	---
Alcoholism......	70,158,000	67,143,000	66,965,000	68,821,000	+1,856,000
FTEs........			202	202	---
Buildings and Facilities.....	1,320,000	1,316,000	1,316,000	600,000	-716,000
Program Management.....	7,620,000	7,292,000	7,292,000	7,390,000	+98,000
FTEs........			149	149	---
Block Grants....	490,000,000	468,930,000	468,930,000	490,000,000	+21,070,000
Total Obligations.	$970,080,000	$928,419,000	$875,451,000	$892,240,000	+$16,789,000
FTEs.....			1,501	1,501	---
Total, Budget Authority...	(968,860,000)	(927,199,000)	(875,323,000)	(892,240,000)	(+16,917,000)

1/ This column excludes $94,629,000 of which $12,158,000 is a reduction for the comparable transfer of Priority Disease Control and Research Projects (AIDS) to the Office of the Assistant Secretary for Health; $1,092,000 which is required to be withheld by Section 515 of the Treasury, Postal Service, and General Government Appropriations Act, 1986; $39,718,000, which is proposed for rescission; and $41,661,000, which is required to be reduced pursuant to the Balanced Budget and Emergency Deficit Control Act of 1985, P.L. 99-177.

General Statement:

The 1987 budget request for the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) principally seeks to maintain approximately the same current services level funding as is available in 1986 after the sequestration required by the Balanced Budget and Emergency Deficit Control Act of 1985 (P.L. 99-177). Not included in this request are the programs proposed for rescission in 1986. All of these had been proposed for funding in NIMH and included the Community Support Program, the Clinical Training Program, and the as yet unauthorized Protection and Advocacy Program.

The primary element in maintaining essentially the 1986 post-sequestration level is the establishment of 1,400 investigator-initiated research project grants as the numents, but in 1987 and beyond it is expected that maintenance of 1,400 total research project grants, including those associated with funds transferred to the Office of the Assistant Secretary for Health for AIDS, will allow for the continued reasonable development of the alcohol, drug abuse, and mental health research community. This policy, in combination with the provision of full current services level funding for intramural research, will permit the agency to continue its core research effort within the current fiscal restraints of the Federal budget.

The quality and significance of research in the ADM field has increased. Some of the most interesting and relevant research findings in the health field today are being uncovered by ADM researchers. In NIMH, we are beginning to understand the chemical and structural basis of such widespread and chronic diseases as schizophrenia and Alzheimer's; to understand the physiological basis of such common human functions as memory, the cognitive process, and sleep; and, to more clearly delineate and establish the increasingly evident important relationship between lifestyle and disease. In NIDA, we have made significant inroads into understanding how drugs act upon and within the brain including the well-recognized break-throughs with regard to opiate receptors and peptides; we are beginning to develop, for the first time, effective treatment programs for cocaine users; and, have made impressive progress in developing techniques for collecting reliable and timely information on national drug abuse patterns which will allow us to more quickly and directly respond to the varying problems of drug abuse throughout the nation. In NIAAA, the importance of genetics to alcoholism continues to be more firmly established as we begin to unveil chemical "fingerprints" that correlate well to susceptibility to physical dependence; research on the effect of alcohol in brain cells and their flexibility has shown that some of these effects resemble changes that naturally occur as part of aging; and, it is becoming clear that alcohol has adverse effects on the immune system. All of these research efforts have important implications for improving health and preventing or ameliorating the effects of disease.

A more quantitative indicator of ADAMHA research indicates that the breadth and quality of the ADAMHA program have never been greater. In 1985 more applications for research were received than in any of the past three years. Of those received, our scientific review committees found about 65% of sufficient quality to be approved for funding. This is a significant increase over a past decade ago when only 45-50% of proposals reviewed were considered worthy of funding. In addition, the 90% percentile priority score for those grants actually funded has improved to 168, the best in the history of the agency.

With regard to the 1987 budget for these activities, the proposal herein will not only provide for 1,400 total research project grants including AIDS grants but also will allow for a 4% increase in the average cost of these awards in both 1986 and 1987 over the actually awarded average cost of 1985. In 1987 the increase is calculated on the direct cost base only since reductions are proposed for indirect costs that limit the total increase. These indirect cost reductions involve a proposed cutback by the Department in the "administrative costs" portion from its current approximate 26% to a cap of 20%. It is estimated that this will save the agency about $4.3 million in research project grant funds and $0.5 million in other research mechanism dollars.

In the other research mechanisms, the 1987 budget will require a limited reduction designed to allow for full continuation costs in some of the various institute programs, assuming the budget as reduced in 1986 by sequestration. Further savings are expected to support a limited number of high priority new projects in such areas as small grants and Research Scientist Development Awards.

As indicated above, the intramural research programs of the agency have been maintained in 1987 at a level that will allow operation at a 1985 current services level. Consequently, these programs, which have been national leaders in their fields, will be able to continue without significant diminution in 1987. The research training program has been reduced slightly in 1987 to reflect a trainee level consistent with 1,400 research project grants. It is estimated that 959 trainees will be supported with the 1986 sequestration budget and that 882 will be provided for in the 1987 budget.

The direct operations and intramural programs are funded at a level that will allow for a total of 1,501 full-time-equivalent (FTE) positions. While this number is somewhat less than the 1,527 indicated by the Congress in its report on the 1986 budget, it represents a level that the agency can operate within for 1986 and 1987 without personnel reductions. Reductions in direct operations will be managed by reducing program contract dollars in such areas as data gathering activities in NIMH, the printing and distribution of prevention materials in NIDA, and a 23% reduction in funding for the National Clearinghouse for Alcohol Information.

As regards to the block grant program, the 1987 budget provides for continuance at the 1985 level. It is the agency's intention to maintain this program at its currently designated level unless special budget circumstances, such as the 1986 sequestration, force its inclusion in an across-the-board reduction. A question arose as to how the 1986 cut should be managed on a State-by-State basis since the authorizing legislation requires all States to be allocated at least the amount funded in 1984 and, by the formula, many States had not participated in gains since then. Pursuant to a departmental Office of General Counsel opinion, the total appropriation amount will be reduced and the formula applied against that lower level, thereby holding harmless those States which had not gained since 1984.

Finally, the 1987 budget includes special budgetary adjustments. The 1986 column, as indicated earlier, has been reduced from appropriated amounts to provide for the proposed rescission of certain programs. It has been further reduced to allow for the withholding of $1,092,000 in accordance with the provisions of the Treasury, Postal Service, and General Government Appropriations Act of 1986. This reduction reflects a cutback of about 10% in consultant service activities and has been distributed by institute pursuant to their activity in this area. Further, in accordance with Administration intent to coordinate all support for Acquired Immunodeficiency Syndrome (AIDS) in the Office of the Assistant Secretary for Health (OASH), the $13,814,000 earmarked for ADAMHA activities in this area has been transferred to OASH in 1987. A comparable adjustment of $2,578,000 for 1985 and $12,157,000 for 1986 has been made as necessary in all budget charts. The budget also assumes that this amount will be directly reimbursed to the agency by OASH. This reimbursement process will allow OASH to more effectively monitor and coordinate the expenditure of funds for certain high-priority diseases such as AIDS whose investigation and control is of paramount importance to the nation.

PROGRAM ACCOMPLISHMENTS

Research advances over the past year have been particularly evident in the neurosciences, basic biochemical processes and interactions between physiological processes and behavior underlying mental illness, alcoholism and drug abuse. This has occurred as a result of the increased agency support of this type of research, the rapid accumulation of converging findings in these areas, and the continuing refinement and more widespread use of sophisticated techniques to study these processes. Several of the more exciting advances made over the last year are identified below.

Mental Health

- Research indicates that Alzheimer's Disease involves regulatory as well as structural defects in the brain. Previous research demonstrated the loss of cholinergic neurons in the forebrain of Alzheimer's patients. The new research shows the increased sensitivity that usually occurs in surviving neurons to compensate for neuronal loss does not occur in Alzheimer's patients. These multiple defects suggest that complex treatments may be required for this disease and focuses research on the interaction between pre- and post-synaptic mechanisms.

- A comparison of CAT scans of schizophrenic patients and normal controls has localized atrophy in the prefrontal brain areas of schizophrenic patients and replicated earlier findings of enlargement of lateral and third ventricles. This finding is significant because of the similarities of symptoms found in persons with known injuries of the dorsolateral prefrontal cortex and the "core" symptoms of schizophrenia including flattened affect, social impairment, apathy, and withdrawal. Further research may identify the specific abnormalities related to the "core" symptoms and provide a foundation for effectively treating them. The "core" symptoms currently are resistant to treatment.

- Research has found that abnormalities of sustained attention are evident in children of schizophrenic parents years before these children develop psychotic symptoms. Other research has shown that schizophrenic children have visual information processing deficits similar to those previously demonstrated to occur in adult-onset schizophrenia. These early cognitive deficits may provide a basis for identifying children at high risk of schizophrenia and for developing intervention strategies.

- A physiological function of sleep has been demonstrated for the first time. Researchers have shown that totally depriving rats of sleep for five or more days produced a variety of metabolic abnormalities that interfered with the ability of the animals to utilize increased caloric intake and resulted in precipitous weight loss. The same dramatic results were then produced by eliminating only a small, but specific sleep stage - Rapid Eye Movement (REM) sleep. It is interesting to note that in depressed humans, total or REM sleep deprivation for limited periods of time, produces an anti-depressant effect. It is believed that sleep deprivation in animals and humans results in noradenergic activation. Malfunctioning of the noraderenergic system is viewed as a major cause of depression. The potential connections among sleep, metabolic processes, and the noradrenergic system have important implications for research on sleep, eating, and depressive disorders. The animal sleep deprivation model used in this research may also be useful as a screen for testing anti-depressant drugs.

Drug Abuse

- Research performed during the last year has clarified a finding that high doses of methamphetamine could produce permanent brain damage. When a cell containing the neurotransmitter dopamine is stimulated, it releases dopamine which either binds to receptors on the adjoining cell or is reabsorbed by the cell for reuse. Under normal conditions, a very small amount of the dopamine is not reabsorbed, but is changed into another substance, a neurotoxin, which has little effect. Methamphetamine has been found to block the reabsorption of dopamine back into the cell resulting in abnormally large amounts of the neurotoxin, thereby causing their destruction. These observations raise the serious concern that the abuse of this drug may result in permanent brain damage or combine with the aging process to produce neurological disease.

- An accomplishment in the area of treatment research has been the development of effective treatment programs for cocaine users. Until very recently there were no generally recognized effective treatment programs for cocaine users. Recently, however, behavioral intervention strategies based on contingency contracting methods have been shown to be effective. For example, drug abusing physicians struggling to maintain a drug-free condition are three times as successful when they have arranged to have their licenses revoked at the first relapse. This arrangement is made by a formal contract with another health care professional, who monitors the physician's drug use and holds a letter from the physician to the State licensing board requesting license revocation, should monitoring reveal a relapse. This technique has been effective with individuals who represent the more affluent drug members of the drug abusing community, including physicians, dentists and nurses. There has been substantial emphasis on integrating this strategy with other approaches and using it for other populations using other drugs.

- The development of techniques for collecting reliable and timely information on drug use levels and patterns has been one of NIDA's major accomplishments. Over the last year significant progress has been made in improving the techniques used in one of our most important survey tools, the National Household Survey. This year's survey will be the largest ever conducted and will, for the first time, contain on oversampling of Black and Hispanic households. The information gathered by this survey, which should be available in March, 1986, will make it possible to develop reliable estimates of the use of drugs in Black and Hispanic households as well as in the population at large.

Alcohol Abuse and Alcoholism

- Efficient new methods for separating various brain proteins have allowed investigators to detect particular patterns of protein genetic variation that correlate well with the susceptibility to develop physical dependence on alcohol. The patterns created by the proteins on the separation medium are characteristic, much like fingerprints. Only a few of the proteins that create these patterns have been identified so far, but ultimately the identification of specific variant proteins among the separated brain proteins will provide clues for understanding the molecular basis of such phenomena as physical dependence on alcohol.

o Recent research indicates that alcohol has adverse effects on every major component of the immune system. Cell-mediated immunity, involving specialized lymphocytes, is an important line of defense against viral infections, including acquired immune deficiency syndrome (AIDS). It is also involved in the body's surveillance mechanism for detecting and destroying tumor cells before they can become established. The numbers of circulating T-lymphocytes are reduced in alcoholic patients, as is the ability of their lymphocytes to undergo blast transformation, a key aspect of immunological mobilization to fight off infectious agents or destroy cancer cells.

o Research has shown that alcohol inhibits the production of a mucosal barrier, or coating of mucus, which normally protects the gastrointestinal tract. This reduction in the effectiveness of the barrier may explain the irritation and bleeding of the gastrointestinal tract, common in chronic alcohol abusers. Moreover, these studies have identified compounds called prostaglandins which protect the gastrointestinal tract from these effects of alcohol. This finding may be of major importance in developing therapies for alcohol-induced damage to the gastrointestinal tract.

1. GENERAL MENTAL HEALTH
Account Summary

	1986 Appropriation	1986 Available after Sequestering	1986 Revised Estimate 1/	1987
Research....	$214,000,000	$204,798,000	$200,445,000	$194,890,000
FTEs........			526	526
Planning & Demos....	12,500,000	11,962,000	954,000	---
Protection & Advocacy...	10,000,000	9,570,000	---	---
Training ...	38,000,000	36,365,000	17,225,000	15,847,000
Dir. Ops....	34,675,000	33,184,000	31,836,000	31,749,000
FTEs........			364	364
Total.......	309,175,000	295,879,000	250,460,000	242,486,000
FTEs........			890	890

1/ Excludes $650,000 which is required to be withheld by the Treasury, Postal Service, and General Government Appropriations Act, 1986; and $5,051,000 for the comparable transfer of AIDS-related research to the Office of the Assistant Secretary for Health, and $39,718,000 which is proposed for rescission.

Narrative

The National Institute of Mental Health (NIMH) provides a national focus for the Federal effort to increase knowledge and advance effective strategies to deal with health problems and issues in the promotion of mental health and the prevention and treatment of mental illness. In carrying out these responsibilities, the Institute: (1) conducts and supports research and research training on the biological, psychological, epidemiological, and social science aspects of mental health and illness; [illegible]ducts and supports research on the development and impro[illegible]al health services and prevention programs and on their administration and financing; (3) collaborates with, and provides technical assistance and data to, State and sub-State authorities to assist them in planning, establishing, maintaining, coordinating, and evaluating more effective mental health programs; (4) collaborates with, provides assistance to, and encourages other Federal agencies and national, foreign, State, and local organizations, hospitals, professional associations, and volunteer groups to facilitate and extend programs to promote mental health and prevent mental illness and to provide for the care, treatment, and rehabilitation of mentally ill persons; (5) collects, analyzes, and disseminates scientific findings and data on the incidence, prevalence, and resources for the treatment of mental illness; (6) carries out administrative and financial management, policy development, planning and evaluation, and public information functions which are required to implement such programs; and (7) exercises administrative and policy oversight for the operation of Saint Elizabeths Hospital.

On August 12, 1985 the National Institute of Mental Health was internally reorganized in order to give greater emphasis to its mission of research, dissemination of research findings, and technical assistance in the promotion of mental health and the improvement of mental health services. The new organizational structure is expected to strengthen the organizational bases for support of research on major mental health problems, and in the scientific fields related to mental health and illness. Research training programs have been integrated with the Institute's research programs.

Within its legislative mandate, the NIMH mission has increasingly focused on the conduct and support of research as the primary activity for understanding the biological and behavioral underpinnings of mental illness and mental health, and for improving the treatment and prevention of mental and emotional disorders. With the repeal of the Community Mental Health Centers legislation, the Federal role in mental health services is now one of providing national leadership. In this more limited role, NIMH now participates in the administration of the Block Grant program and manages programs to demonstrate the improved development of systems of care for adults and children who are severely and chronically mentally ill or seriously emotionally disturbed. The Institute also provides consultation and technical assistance on the treatment and rehabilitation of the mentally ill.

a. Research (Section 301 of the Public Health Service Act)
1987 Authorization: Indefinite

Budget Authority:

	1986 Appropriation	1986 Available after Sequestering	1986 Revised Estimate 1/	1987	Increase or Decrease
Research...	$214,000,000	$204,798,000	$200,445,000	$194,890,000	-$5,555,000
FTEs.......			526	526	---

1/ Excludes $650,000 which is required to be withheld by the Treasury, Postal Service, and General Government Appropriations Act, 1986: and $3,703,000 in research activities related to AIDS, comparably transferred to the Office of the Assistant Secretary for Health in 1987. NIMH staff will continue to administer the program in 1987, on a reimbursable basis.

Purpose and Method of Operations: The purpose of this program is to develop new knowledge about. and approaches to, the causes, diagnosis, treatment, prevention, and control of mental illness. To achieve this goal, the National Institute of Mental Health funds extramural research programs through grants, contracts, and cooperative agreements made to investigators affiliated with hospitals, academic and research institutions, and other organizations. NIMH carries out its own research through the intramural research program which has laboratories located on the campus of the National Institutes of Health (NIH) and on the grounds of Saint Elizabeths Hospital.

The research programs of NIMH cover a broad spectrum of basic and applied investigations related to the etiology, diagnosis, treatment and prevention of mental illness. These studies are conducted by a wide array of scientists in the biological, behavioral, and medical sciences and such hybrid specialties as psychoneuroendocrinology immunopharmacology, biochemistry, and pharmacogenetics. The studies range from recordings of electrical activity in single nerve cells to the emotional and cognitive development of individuals to the functioning of families and support groups to prevalence rates of mental illness in various populations.

Beginning this fiscal year, NIMH has selected several research areas as priorities. These areas are basic research on the brain and behavior, schizophrenia, disorders of children and adolescents, mental disorders of the aging, behavioral medicine, and impulse control. In this budget request, NIMH has increased the percentage of funds designated for these areas. Selection of the priority areas was based on the scientific opportunities available in them or the need to substantially expand the knowledge base to deal with major problems related to them. The reorganization, discussed in the introductory material, has not affected the array of funding mechanisms used for the conduct of research. However, the reorganization has revised the structure of the research divisions, organizing them principally around broad areas of scientific research. Some mechanisms which had previously been centralized - the Research Scientist Development program, for example - have been decentralized and incorporated with the project grant mechanisms in the scientific research areas to provide a full complement of opportunities to stimulate the field and coordinate development. The Intramural Research program has not been affected by the reorganization.

This fiscal year NIMH plans a major effort to disseminate what is known about the etiology, diagnosis, and treatment of depression. Known as Project DART (Depression Awareness, Recognition and Treatment) the effort is directed at general health professionals, mental health professionals, and the general public. This effort is deemed necessary for three reasons. First, depression is the most treatable of the major mental disorders. Nevertheless, only about a third of the individuals afflicted with the illness receive treatment. Second, general health professionals need to improve their skills in diagnosing and treating individuals suffering from depression. Third, the general public has shown a desire to know more about depression as demonstrated by the 247,000 requests NIMH has received for its consumer information pamphlet, "Depression: What We Know", during Fiscal Year 1985.

NIMH is beginning to quantitatively measure the output of its research programs. Citation analysis is the initial technique being employed. An analysis of data published by the Institute for Scientific Information on the 1,000 contemporary scientists most-cited in the physical, chemical and life sciences from 1966 to 1978 shows that NIMH-supported researchers are among the most-cited scientists in several disciplines that are central to the mission of the Institute. NIMH researchers, extramural and intramural, rank first and fourth in cell biology; first, second and fifth in pharmacology; second, fourth, fifth, sixth and tenth in neuropharmacology; and first through fifth in psychiatry. NIMH has supported 100 percent of the most-cited researchers in psychiatry, 60 percent in neuropharmacology; and 21 percent in pharmacology. Overall, the 42 investigators have contributed to 16 disciplines including several fields that are becoming increasingly important to mental halth research--biochemistry, molecular biology and immunology.

The following table provides 1985-1987 numbers of awards and funding levels for grants and contracts, displayed according to type of award. This information is followed by another table which provides estimates of funding levels in the Institute's major areas of research.

General Mental Health

Research by Type of Award

	1985 Actual 2/		1986 Available after Sequestering		1986 Revised Estimate 1/2/		1987	
	No.	Amount	No.	Amount	No.	Amount	No.	Amount
Research Projects:								
Noncompeting	437	$ 59,767,000	502	$ 74,787,000	493	$ 73,433,000	503	$ 76,014,00[illegible]
Competing:								
Renewal..........	120	17,919,000	117	17,730,000	115	17,481,000	117	17,757,0[illegible]
New..............	192	24,536,000	157	20,460,000	152	19,889,000	140	18,171,0[illegible]
Supplemental.....	(29)	959,000	(54)	2,285,000	(54)	2,244,000	(43)	1,824,0[illegible]
Subtotal competing......	312	43,414,000	274	40,475,000	267	39,614,000	257	37,752,0[illegible]
Total, research projects (BA)...	749	103,181,000	776	115,262,000	760	113,047,000	760	113,766,000
(With AIDS Reimbursement).	(763)	(104,858,000)	(776)	(115,262,000)	(776)	(116,262,000)	(776)	(116,081,[illegible])
Other Research Mechanisms:								
Centers:								
Noncompeting	14	5,597,000	16	7,935,000	16	7,935,000	19	9,314,0[illegible]
Competing........	6	3,694,000	6	2,386,000	6	2,386,000	--	-
New..............	2	847,000	3	962,000	1	484,000	--	---
Supplemental.....	--	---	--	---	--	--	--	---
Subtotal.......	22	10,138,000	25	11,283,000	23	10,805,000	19	9,314,[illegible]
Research Scientist:								
Noncompeting.....	114	6,355,000	127	7,129,000	126	7,074,000	121	6,776,[illegible]
Competing........	22	1,177,000	24	1,340,000	24	1,340,000	9	500,[illegible]
New..............	27	1,487,000	12	688,000	10	588,000	8	481,000
Supplemental.....	(5)	128,000	--	--	--	---	--	---
Subtotal.......	163	9,147,000	163	9,157,000	160	9,002,000	138	7,757,[illegible]
Small Business Innovation Research:								
Noncompeting......	2	400,000	2	416,000	2	416,000	4	600,[illegible]
Competing.........	1	226,000	4	600,000	4	600,000	4	600,[illegible]
New..............	17	788,000	14	855,000	14	855,000	9	518,000
Supplemental......	--	---	--	---	-	--	--	---
Subtotal........	20	1,414,000	20	1,871,000	20	1,871,000	17	1,718,[illegible]
Small Grants (New):	72	1,508,000	66	1,483,000	64	1,433,000	22	500,000
Cooperative Agreements:								
Noncompeting.....	20	4,962,000	20	4,684,000	20	4,684,000	11	2,842,000
Competing........	6	954,000	3	945,000	3	945,000	--	---
New..............	1	259,000	1	185,000	1	185,000	--	-
Supplemental.....	(5)	747,000	--	---	--	--	--	-
Subtotal.......	27	6,922,000	24	5,814,000	24	5,814,000	11	2,842,000
Contracts:								
Renewal..........	8	2,492,000	2	1,550,000	2	1,550,000	3	1,500,000
New..............	6	1,160,000	22	3,254,000	14	1,799,000	--	---
Subtotal.......	14	3,652,000	24	4,804,000	16	3,349,000	3	1,500,[illegible]
Subtotal, other research mechanisms..	318	32,781,000	322	34,412,000	307	32,274,000	210	23,631,[illegible]
(With AIDS Reimbursement).	(305)	(32,906,000)	(322)	(34,412,000)	(322)	(33,762,000)	(233)	(26,[illegible])
Total extramural research.(B.A.)....	1,067	135,962,000	1,098	149,674,000	1,067	145,321,000	970	137,397,[illegible]
(With AIDS Reimbursement).	(1068)	(137,764,000)	(1098)	(149,674,000)	(1098)	([illegible],024,000)	(1009)	(142,432,000)

General Mental Health

Research by Type of Award

	1985 Actual 2/		1986 Available after Sequestering		1986 Revised Estimate 1/2/		1987	
Intramural Research:	No.	Amount	No.	Amount	No.	Amount	No.	Amount
Personal Services...	--	20,315,000	--	22,217,000	--	22,217,000	--	22,788,000
Other Objects........	--	12,696,000	--	10,610,000	--	10,610,000	--	11,783,000
Payments to NIH.....	--	18,983,000	--	18,563,000	--	18,563,000	--	19,031,000
Payments to SEH.....	--	3,570,000	--	3,734,000	--	3,734,000	--	3,891,000
Total Intramural Research..........	--	55,564,000	--	55,124,000	--	55,124,000	--	57,493,000
Total (B.A.).....	1,051	191,526,000	1,098	204,798,000	1,067	200,445,000	970	194,890,000
(With AIDS Reimbursement).	(1060)	(193,328,000)	(1098)	(204,798,000)	(1098)	(204,148,000)	(1009)	(199,925,000)

1/ Excludes $650,000 which is required to be withheld by the Treasury, Postal Service, and General Government Appropriations Act, 1986; and

2/ Excludes the amount of $1,802,000 in 1985 and $3,703,000 in 1986 for AIDS-related research comparably transferred to the Office of the Assistant Secretary for Health. NIMH will continue to administer this program on a reimbursable basis in 1987. Also reflects comparable transfer of $1,858,000 in 1985 for NIH Management Fund.

Research by Program Distribution

	1985 1/	1986 after Sequestering	1986 Revised Estimate 1/2/	1987
Extramural Program:				
Basic Studies in Brain and Behavior................	$ 40,176,000	$ 45,266,000	$ 45,266,000	$ 44,032,000
Schizophrenia Disorders.....	12,485,000	15,080,000	15,080,000	14,669,000
Depression & Manic Depressive Illness..........	22,455,000	21,874,000	21,874,000	19,937,000
Mental Disorders of Aging...	7,479,000	8,274,000	8,274,000	8,048,000
Childhood Disorders.........	15,654,000	17,432,000	17,432,000	16,957,000
Anxiety Disorders............	4,684,000	4,589,000	4,589,000	4,183,000
Behavioral Medicine and Stress..................	4,409,000	7,426,000	3,723,000	3,622,000
Epidemiology.................	13,259,000	13,653,000	13,653,000	12,444,000
Prevention..................	5,337,000	6,015,000	6,015,000	5,482,000
Other Mental Health Areas...	10,024,000	10,065,000	9,415,000	8,023,000
Total Extramural Program....	135,962,000	149,674,000	145,321,000	137,397,000
(With AIDS Reimbursement)..........	(137,764,000)	(149,674,000)	(149,024,000)	(142,432,000)
Intramural Research:				
Basic Studies in Brain and Behavior................	23,838,000	24,181,000	24,181,000	24,769,000
Schizophrenic Disorders.....	5,971,000	6,058,000	6,058,000	6,456,000
Depression & Manic Depressive Illness..........	7,917,000	7,404,000	7,404,000	7,563,000
Mental Disorders of Aging...	3,820,000	3,875,000	3,875,000	4,265,000
Childhood Disorders.........	5,536,000	5,615,000	5,615,000	5,891,000
Anxiety Disorders............	2,049,000	1,916,000	1,916,000	1,957,000
Behavioral Medicine and Stress..................	3,321,000	3,106,000	3,106,000	3,559,000
Epidemiology.................	637,000	595,000	595,000	608,000
Prevention..................	774,000	786,000	786,000	803,000
Other Mental Health Areas...	1,701,000	1,588,000	1,588,000	1,622,000
Total Intramural Program....	55,564,000	55,124,000	55,124,000	57,493,000
Total Research...............	191,526,000	204,798,000	200,445,000	194,890,000
(With AIDS Reimbursement)..........	(193,328,000)	(204,798,000)	(204,148,000)	(199,925,000)

1/ Excludes the amount of $1,802,000 in 1985 and $3,703,000 in 1986 for AIDS-related research comparably transferred to the Office of the Assistant Secretary for Health. NIMH will continue to administer this program on a reimbursable basis in 1987. Also reflects comparable transfer of $1,858,000 in 1985 for NIH Management Fund.

2/ Excludes $650,000 which is required to be withheld by the Treasury, Postal Service, and General Government Appropriations Act, 1986.

Rationale for the Budget Request: The 1987 request will support a total of 760 research project grants, including 257 new and competing awards and 503 continuations. The major areas of emphasis will be research on schizophrenia, the special mental health problems of children and the elderly, and on promising areas of research in the neurosciences, behavioral sciences, and health and behavior. Funding will remain stable for research on anxiety, epidemiology, and depression. In 1987 no new or competing awards will be made in the Research Centers, Cooperative Agreement, or Contracts programs. However, the Institute will meet its continuation award commitments in these areas. The Small Grants and Research Scientist Development programs will continue at reduced levels.

BRAIN AND BEHAVIOR

Basic research on the brain and behavior expands our fundamental knowledge base related to mental health, and the mental illnesses that afflict an estimated 22.1 million Americans, 18 years and older. The Research Triangle Institute estimated the direct treatment and support costs for mental illness in this country in 1983 at $33 billion.

Basic studies of the structure and functioning of animal and human brains explore neural networks, cell structures, neurotransmitters, metabolic activity, genes, cerebral blood flow, and hormones to delineate the biological basis of mental health and mental illness. Basic studies of animal and human behavior investigate learning, memory developmental processes, coping mechanisms, stress, interpersonal skills, and family functioning. These efforts help to develop insights into the psychological, social and environmental bases of mental health and mental illness. This twin thrust to discover the relationships between brain function and behavior that underlie mental health and mental illness also is important for understanding some aspects of physical health and physical illness. Independent studies estimate that lifestyles and behavior patterns contribute up to 50 percent of the mortality from the 10 leading causes of death in this country.

Research on the chemical distribution of neuromodulators and their circuitry in various brain regions over the last 10 years is changing our conception of the organization of the brain. The traditional concept of the brain was based on the position and arrangement of cells in tissue. Research now indicates a more sophisticated concept of a structure composed of chemically identifiable neuronal groups with particular projection patterns into other parts of the brain. This new perspective, made possible largely by the development of modern tracing techniques, has led to a re-examination of traditional nuclear boundaries, the identification of subcompartments with nuclei that are chemically unique, and a reconsideration of the functional significance of some brain structures.

Basic research on the dopamine system continues to clarify the causes and treatment of schizophrenia. The process of co-transmission (the secretion of more than one transmitter by a single neuron) appears to be involved in the illness.

Studies have discovered that a subpopulation of neurons in the mid-portion of the brain contains dopamine (DA) and the neuropeptide cholecystokinin ((CCK). These neurons stimulate areas of the limbic system long implicated in schizophrenia. Decreased levels of CCK have been found in schizophrenic patients with prominent negative symptoms. These investigations suggest that this subpopulation of neurons is jointly modulated by DA and CCK. Several clinical studies are testing a treatment that increases CCK within the neuron to modulate the disordered dipamine function. Other studies will examine the process of co-tranmission to determine how it works.

Discovery of the process of co-transmission has greatly increased interest in the function of neuropeptides. Research increasingly suggests that neuropeptides are co-localized in combination with the classical amine transmitters and that these combinations have specific functional significance in mental disorders. A major effort is required to document neuropeptides which are present in brain tissue, to identify the nerve cells in which they are found, and to trace the neuronal circuits which they form. Progress in this area also depends on the development of drugs that can be used as probes to examine specific processing enzymes, release and re-uptake mechanisms, receptors, and post-receptor mechanisms.

Studies of the consequences of chronic neuroleptic administration on the biochemistry and electrophysiology of DA neurons has produced several important findings. First, the time-dependent therapeutic action of neuroleptics may result from a combination of DA receptor blockade in the short-run and DA cell inactivation in the long-run. Second, neuroleptics that have a tendency to produce tardive dyskinesia decrease activity in DA cell bodies in the substantia nigra. Third, all three major DA pathways are involved in the therapeutic action of antipsychotic drugs. Additional work is needed on designing drugs that act quicker and produce more specific actions. The relative importance of the three pathways involved in the therapeutic action of neuroleptics also needs to be determined.

The need to better understand the influence of psychoactive drugs on neurons has focused research on post-receptor mechanisms--the biochemical and biophysical events stimulated or blocked when neurotranmmitters or drugs bind to receptors. These studies are attempting to identify and characterise the cellular and behavioral significance of these post-receptor phenomena. The development of therapeutic agents which selectively interfere with or modify the action of these mechanisms may lead to important new treatments of mental illness.

Alzheimer's Disease (AD) appears to involve regulatory as well as structural defects. Earlier research demonstrated a severe and slective degeneration of basal forebrain cholinergic neurons in Alzheimer's patients. Recent research indicates that the post-synaptic supersensitivity that usually occurs in surviving neurons to compensate for neuronal loss does not occur in AD patients. It thus appears that one of the major mechanisms of compensation for neuronal deficits within the central nervous system is absent in Alzheimer's patients. Further investigations of these combined defects requires studies that encompass pre- and post-synaptic functioning of cholinergic neurons. These studies involve measurement of choline uptake by synaptosomes isolated from specific brain regions; acetylcholine synthesis and storage, and responses medicated by muscarinic receptors. Performing such studies rests on the capability of obtaining human post-mortem brain tissue less than one hour after a person's death.

The first demonstration of a physiological function of sleep is perhaps one of the most important findings in sleep research in the last decade. Research has shown that totally depriving rats of sleep for 5 or more days produced metabolic changes that were lethal to the animals. Preliminary results suggest that despite large increases in food intake, sleeplessness induced a variety of metabolic abnormalities that interfered with the ability of the animals to utilize caloric intake and produced precipitous weight loss. More definitive studies demonstrated that elimination of only a small, but specific sleep stage - REM sleep - produced the same dramatic effects. It is interesting to note that in depressed humans, total or REM sleep deprivation for limited periods of time produces an antidepressant effect. Research on the sex hormone, testosterone, is beginning to spell out its impact on the organization and functioning of the brain. A nucleus has been identified in the rat brain that shows sex differences in synaptic organization that can be reversed if testosterone levels are manipulated neonatally. In addition, testosterone has been shown to directly affect a subset of brain cells that controls scent-marking and sexual behavior in the gerbil. This is the first time this phenomenon has been demonstrated in the mammalian brain. It also is the first identification of anatomical markers in brain areas thought to control motivation. Current research is tracing the pathways involved in these behaviors and specifying the particular components of behavior affected. By identifying specific functionally defined units in the central nervous system that control specific behaviors, it may become possible to directly intervene at the cellular/molecular level to correct or treat behavioral symptoms.

Interventions at the molecular level will depend on our understanding of messenger RNA (mRNA). These "messages" are the "copies" of the genes which are used by all of the body's cells as the templates for protein synthesis. Measurements of mRNA's and their product proteins can yield very detailed information about which genes in a particular cell are activated at any given time. Such information is invaluable in deciphering genetic and developmental aspects of disease processes. NIMH is increasing the number of grants its supports in this area.

Besides continuing to exploit the neuroscience research opportunities described above, NIMH will promote the creation of standarized approaches to functional brain imaging analysis and the examination of brain plasticity including neurogenesis in vertebrates.

Behavioral science research is making major contributions to our understanding of memory and cognitive processes. Memory losses and learning problems are among the most frequent effects of mental illness, brain damage, aging, and stress. With a basic understanding of cognitive processes and functions it may become possible to use rational behavioral or psychopharmacological means to prevent dysfunctions or to compensate for deficient processes.

Research has demonstrated experimentally that memory and emotional states are linked This research showed that memories are emotion dependent, that a person's mood influences what is learned and recalled. In remembering, people recall primarily events which support their current mood. Depressed persons, for example, selectively remember or retrieve only depressing events or interpretations of their lives.

Behavioral researchers are also looking into information processing, an ability frequently decreased by mental illness. Current theory offers two fundamentally different forms of information processing - automatic and controlled (attentive). Automatic processing occurs when a task is well learned and has been committed to long-term memory. These processes are fast, parallel and require little or no attentiveness or intention. They are difficult to modify and are habitual. Controlled processes are those which concern novel and inconsistent information. These require little training to initiate, are slow and serial in nature, involve memory scanning, and a focusing of attention.

Research indicates that depression as well as stress states have a larger effect on controlled processing than on automatic processing. Research further indicates that subjects having compulsive anxiety about performance do not allow an automatic behavior to occur without carefully reviewing it, thereby, reducing their effectiveness at what should be an automatic task. Understanding procedures that help subjects to allow automatic processing to occur may be useful in treating some types of obsession and mental retardation.

Work is progressing on the development of a general memory model that distinguishes between memories arising from experienced perceptual events and those that stem from internal reflections or thought. The development of such a model would be important for understanding normal human cognition as well as for clarifying abnormal effects such as hallucinations or distorted memory functions found in thought disorders and amnesia. Results, so far, indicate that perceived and imagined memories differ in significant ways.

Behavioral research will continue to explore memory and cognitive processes; the development of emotions, the emergence of psychopathology in family systems, processes and mechanisms for coping with psychosocial stress, and methodology related to longitudinal studies and family interaction. In addition, behavioral research will begin looking at non-human primate models of mental illness and the environmental conditions affecting genetic potentials for psychopathology.

SCHIZOPHRENIA

Schizophrenia remains the most complex, puzzling and, because of its tendency toward chronicity, the most severe of the major mental illnesses. With a lifetime prevalence of 1 percent of the general population, 2-3 million Americans are affected by this disorder. Of those initially affected, it is estimated that at least 50 percent will experience some form of intermittent disability throughout their lifetime; an additional 25 percent will never recover from the initial episode and will require life-long care. In 1980-81, schizophrenia was either the first or second most frequent primary diagnosis for admission to each type of inpatient psychiatric service in this country.

Research on schizophrenia continues to search for the causes of the illness; to dissect its symptom complexes; to identify potential predictors of treatment response, and to seek ways to prevent relapse.

Research is beginning to suggest that some forms of schizophrenia may be auto-immune diseases. Two antibodies have been found in the blood serum of some schizophrenics. The first antibody occurs in schizophrenics never treated by medication and in some first-degree relatives who are not psychotic. The second antibody occurs in some schizophrenics who have been exposed to neuroleptic medication. Preliminary results from another study suggest that schizophrenic patients who carry the antigen HLA-BW-44 are more likely to develop auto-immune antibodies when treated with chlorpromazine rather than a nonphenothiazine antipsychotic drug. Researchers believe that patients who carry the HLA antigen and auto-immune antibodies are likely to develop severe tardive dyskinesia.

Research using the narcotic antagonist, naloxone, decreased schizophrenic hallucinations, suggesting that such hallucinations may be caused by endorphins, the brain's own morphine-like compounds. Research employing batteries of neuropsychological tests are producing results consistent with the hypothesis that schizophrenics have reduced cortical activity in frontal lobes, a view also emerging from studies of cerebral blood flow measures and CT and PET scans. Other research indicates that the flat affect seen in schizophrenics is associated with right hemisphere dysfunction and a reduction in the dynamic range of a patient's voice. These patients, who tend to say each word equally loud, also have trouble perceiving emotion in others and in expressing emotion in their own faces. Patients exhibiting these characteristics tend not to respond to treatment.

The heterogeneity of the findings reported above and many others have convinced researchers that schizophrenia is not a single disease produced by a single cause. Based on that conclusion, NIMH is launching a major effort to identify homogeneous subtypes of the illness. The subtypes would be based on similar etiologies, courses of illness, response to treatment and other factors. This effort will also include biological markers and environmental factors such as anoxia at birth, viral and autoimmune causes, and stress.

Since research further indicates a genetic predisposition to the illness, a major effort will be made to identify this predisposition through studies of twins, families with multiple generations of schizophrenia or multiple members of the same generation with the illness, and the schizophrenia spectrum -- the extent of schizophrenia related disorders in families of schizophrenia. These studies will employ techniques developed in molecular genetics.

Researchers are also exploring a central issue in the diagnosis of schizophrenia - the nature of the "core" symptoms of the disorder. One conceptualization classifies the symptoms as positive - hallucinations and delusions - and negative - blunted affect, retardation, and lack of interest. This schema has received some support from research that found a bimodal distribution of dopamine receptor density in three brain areas of schizophrenics. In addition, negative symptoms respond less favorably to neuroleptic medication than do the positive symptoms. Some researchers believe that negative symptoms need to be viewed as a multidimensional phenomenon whose components vary independently of one another. Other research has shown that eye tracking dysfunctions and abnormalities of sustained attention might be useful in assessing vulnerability to schizophrenia.

The nature of the "core" symptoms of schizophrenia, however, remains unclear. To rectify this situation NIMH is focusing research on patterns of positive symptoms, the degree to which negative symptoms are specific to schizophrenia, the measurement and role of affect in the illness and its prognosis, and the use of brain imaging techniques to determine how the brain functions during different symptom states.

In addition, research is examining treatment response in schizophrenia. A study has shown that lithium associated antipsychotic response involves an extreme lithium red blood cell/plasma ratio, a chemical deficiency in the red blood cell membrane, an elevated growth hormone response to apomorphine, and the frequency of schizophrenia spectrum disorder in relatives. Other research suggests that the level of homovanillic acid (HVA) in blood plasma may be a useful predictor of response to antipsychotic drug treatment. Patients who improved after receiving antipsychotic drugs had high plasma HVA prior to treatment and showed a significant decline during the first week of treatment; nonimproving patients had initially lower plasma HVA concentrations and showed little change over time.

Major progress has been made in the prevention of relapse in some schizophrenics. A study has revealed a strong relationship between the reduction of Expressed Emotion (hostility and criticism) and relapse in young male patients receiving medication. In this investigation, no patients whose families demonstrated a change from high to low Expressed Emotion relapsed. All relapses occurred in those patients whose families remained high in Expressed Emotion. In current clinical practice, about 70 percent of schizophrenic patients relapse within 2 years of discharge from hospitalization. The best controlled clinical trials of medication treatment still yield a 40 percent relapse rate.

In addition, investigations will continue on continuous or intermittent treatment regimens, combined pharmacologic and psychosocial therapies, side-effects, and relapse.

DEPRESSION AND MANIC DEPRESSIVE ILLNESS

The affective disorders, which include mania and various forms of depression, are probably the most destructive group of mental illnesses in the United States in terms of prevalence, mortality, economic cost, and impact on families. One in four women and one in nine men will suffer from a clinical depression at some time in their lives. Epidemiological Catchment Area (ECA) studies found an estimated 9.4 million Americans, 18 years and older, suffer from affective disorders in any six-month period. Many more will suffer from significant depressive symptomatology. In addition, several psychiatric disorders are either within the affective disorders spectrum or are frequently associated with affective disorders, including premenstrual syndrome, personality disorders, and alcoholism. The most tragic complication of depression is suicide.

Appropriate use of several types of medications, psychotherapies, electroconvulsive therapy and various combinations of the above can help about 80 percent of those afflicted; yet, only one in five persons seek treatment.

Research continues to identify the myriad of malfunctions underlying the affective disorders. An adoption study has shown that depressive disorders are heterogenous in genetic and environmental causes. Non-psychotic depressions experienced before age 30 are largely environmentally determined as shown by psychopathology in depressed adoptees, but not in their biological parents. In contrast, depressed adoptees with later onset are more likely to have biological parents with depression.

Other research indicates depression may involve decreased metabolic brain activity, an over-supply of acetylcholine, and prenatal exposure to the synthetic estrogen (Diethylstilbestrol).

Research further indicates that there are abnormal levels of cortisol and growth hormones in depressed persons during the first 100 minutes after sleep onset; that there is a high degree of association between premenstrual depressive syndrome changes and a lifetime diagnosis of a major depressive disorder; that suicidal behavior is not confined to those who have a diagnosis of affective disorder, and that patients with anorexia nervosa or bulimia do not exhibit the type of sleep disturbances characteristic of patients with major depressive illness.

Research on the treatment of affective disorders suggests that antidepressant treatment should be continued until the patient has been free of significant symptomatology or has been functioning at his or her usual level for at least four months. In addition, there are 23 controlled trials establishing the efficacy of different psychosocial treatment approaches for major depressive disorders. In addition, research has produced the first pharmacotherapeutic guidelines for treating borderline personality patients. The research suggests that low-dose neuroleptic medication, haloperidol, may be effective across a wide spectrum of affective, cognitive and behavioral manifestations of this disorder. The tricyclic antidepressant, amitriptyline, appears to be a poor treatment choice despite the prevalence of affective symptoms in borderline patients.

Research on affective disorders will focus on identifying psychobiological markers of different types of affective disorders, the course of the various disorders, the role of personality factors in the illness, and the development of valid predictors of suicide.

These studies can be supported within a relatively stable budget. When compared to the other major mental illnesses, a wide variety of therapies is now available, and the principal need is to encourage those who have not sought treatment to do so.

MENTAL DISORDERS OF AGING

Elderly Americans (age 65 and over) number over 27 million or 11 percent of the population; estimates covering the next 40 years project the growth to 55 million, fully 20 percent of the population. As risk factors multiply in old age through physical limitation and deterioration, social disruption, and psychological loss, there are increases in the dementing disorders (especially Alzheimer's disease), symptoms of depression, and behavioral problems such as sleeplessness, agitation, and confusion. The dementias represent a devastating problem in this population; their prevalence rises for 3 percent for people at age 65 to over 20 percent for those 80 years of age or older.

Five percent of the Nation's aged live in institutions. Of these, about 12 percent are in mental hospitals, with the remainder in nursing and other types of homes for the aged and chronically ill. Elderly patients comprise 5.5 percent of the additions and 27 percent of the resident patients in State and county mental hospitals. Those in nursing and personal-care homes are frequently in need of mental health services; about 80 percent have some degree of mental impairment, with senile dementia (Alzheimer's disease) the most frequently observed condition.

The modest effects produced by using cholinergic drugs to reduce memory loss and other cognitive symptoms that are the hallmarks of Alzheimer's disease (AD) suggest that either inadequate levels of the drugs are reaching the brain or that more complex interventions are necessary. A controlled study is testing the inadequate drug level hypothesis by implanting a pump and catheter in the brains of AD patients to deliver the compound bethanecol. The possibility that more complex interventions are necessary are supported by studies showing that AD may involve multiple neurotransmitter and metabolic deficits and regulatory as well as structural problems. Positron Emission Tomography (PET) is being used to determine the nature of brain metabolic changes in AD and to examine how these changes might be altered by various experimental drugs.

Efforts are also underway to solve two of the major impediments to clinical drug evaluation in AD. The first concerns the lack of agreement between drug effects observed in animal models of aging and AD and those observed in clinical trials on humans. A collaborative effort has been organized to develop new animal models of AD and to create homologous behavioral tests in humans and non-human primates to allow effective screening of large numbers of drugs of possible utility in AD. The second obstacle is the lack of valid and reliable clinical assessment instruments for assessing drug effects in AD patients. This obstacle is being addressed by the development of psychometric tests closely related to AD symptomatology; a standard test of apraxia, a frequent symptom of AD; and tests of logic, inference and forgetting.

Research is also focusing on depression, sleep disorders and psychosis in the elderly. This research suggests that monoamine oxidase inhibitors (MAOIs) may have a role in treating depressed elderly patients. MAOIs are used less extensively in the elderly because of the risk of hypertensive crises when the drug is combined with certain foods and medications. Research is also searching for alternative drugs treatments for sleep disorders because the most widely prescribed medication for sleep, flurazepam, may cause several major problems including incapacitating daytime drowsiness in the elderly. Another study is attempting to determine whether psychotic disorders in elderly persons can be controlled by carefully monitoring drug plasma levels to permit the use of lower doses of neuroleptic drugs, thereby, reducing the probability of inducing tardive dyskinesia.

NIMH will pursue research on the treatment and management of Alzheimer's disease with a special focus on family issues; the elderly with depressive illness who do not respond to treatment (about 25 percent); the chronically mentally ill elderly; the emergence of late-onset schizophrenia or paraphrenia; the major psychoses, and the mental health consequences of physical illness in the elderly.

DISORDERS OF CHILDHOOD AND ADOLESCENCE

An estimated 12 percent of youngsters under age 18--some 7.5 million--are subject to various child and adolescent disorders at any given time. These disorders include autism, schizophrenia, depression, anxiety, attention deficit disorders, conduct disorders, psychiatric disorders occurring in the mentally retarded and developmentally disabled, and psychophysiological illnesses such as anorexia and bulimia. Despite the dimensions of this problem area, research on these disorders has lagged behind research on adult psychopathology.

Adolescence is the only age grouping in which the death rate is rising. Improved health measures have prolonged life for the elderly and have increased survival in early childhood. But teenagers are dying in increasing numbers due to suicide, homicide, drug abuse, and alcohol-related automobile accidents. High rates of teenage pregnancy and adolescent crime also are present. Epidemiological research and behavioral studies on adolescent parent-peer conflict, childrearing practices, and quality of life consistently show that 15-25 percent of young people and their familes are involved in such difficulties.

Autism affects about 5 children out of 10,000, with boys affected five times more often than girls. A study of twin pairs has found a concordance rates of 95.7 percent in identical-twin pairs and 23.5 percent in fraternal-twin pairs. This finding strongly suggests that a genetic factor is involved in the illness. Recent studies of the causes of autism have focused on genetic factors and on the possibility that autoimmune disorders may be involved in some cases. The possibility that some types of autism may involve autoimmune disorders arose when researchers, investigating elevated levels of serotonin in autistic persons, discovered circulating antibodies that inhibited the binding of serotonin to receptors in the frontal cortex. Other research has developed a behaviorally based assessment scale for autism that may be useful in making timely and accurate diagnoses and in identifying subgroups within this illness.

Childhood attention deficit disorder, with or without hyperactivity (ADD/H), is estimated to affect 2 to 4 percent of children (mostly boys) ages 6-12 years. While the short term efficacy of stimulant medication to enhance attention and reduce disruptive behaviors has been demonstrated, there is a growing consensus that the failure to find "carryover" effects from these interventions in childhood may indicate that ADD/H is not "outgrown", but continues to manifest itself throughout adolescence and into adulthood. Other research has shown that the response of children with ADD to the drug, methylphenidate, can be predicted from their pre-drug behavioral state, but not from blood-levels of the drug. This finding is leading investigators to reexamine current theories of the illness.

Research has found that abnormalities of sustained attention are evident in children of a schizophrenic parent years before these children develop psychotic symptoms. Other research has shown that schizophrenic children have visual information processing deficits similar to those previously demonstrated to occur in adult-onset schizophrenia. These early cognitive deficits may provide a basis for identifying children at high risk of schizophrenia and for developing intervention strategies.

Researchers have also found a distinctive endocrine pattern, namely low growth hormone response to insulin-induced hypoglycemia, but normal cortisol and prolactin levels, in depressed children. Other research has shown that psychosocial deficits in pre-pubertal children with major depression do not seem to improve with pharmacological treatment. These children probably require social skills training.

NIMH has identified the following key areas for future study: Epidemiology studies of the extent of childhood disorders, their distribution in the population and the risk factors associated with the disorders; the causes, diagnosis, treatment and prevention of childhood and adolescent depression; the links between childhood and adult depression; the multiple determinants of adolescent suicide; the diagnosis and assessment of ADD/H and conduct disorders; the underlying neurobiologic factors and psychosocial conditions of autism; vulnerability to schizophrenia in the formative years; appropriate treatment for psychiatric disorders in the mentally retarded and developmentally disabled; development of effective psychotherapies for childhood and adolescent disorders; and the assessment of prevention strategies targeted to infants and mothers within high-risk populations.

ANXIETY

Anxiety disorders are the most prevalent of all mental illnesses excluding substance abuse disorders in this country. About 8 percent of the population (18 years and older) or some 13 million adults are affected. Anxiety includes generalized anxiety, panic, phobic and obessive-compulsive disorders. A person may suffer from one or more of these types either sequentially or simultaneously. In addition, anxiety can occur as part of many psychiatric disorders, including depression, schizophrenia, organic brain syndromes, senile dementia, alcoholism and other substance abuse. Anxiety may also accompany some physical disorders and growing evidence suggests that it can worsen such dangerous illnesses as hypertension, heart disease and peptic ulcer.

A study of the effects of pharmacotherapy and psychotherapy in the treatment of agoraphobic patients with panic attacks found that both treatments are effective but that the combination was no more effective than either treatment alone. The study also indicated that dosages less than 150mg/day of the antidepressant, imipramine, were considerably less effective than higher dosages. This study will be expanded to include other anxiety disorders and some of the newer antidepressants that have more specific effects than imipramine.

An area of increasing importance in anxiety research is the co-morbidity of major forms of psychopathology with anxiety disorders. Depressed persons frequently suffer from obsessive thoughts, generalized anxiety, panic attacks, and other symptoms of anxiety. Persons with an anxiety disorder are frequently depressed. The most pressing research problem in this area is measuring co-morbid symptoms for the purpose of differential diagnosis. A proposed solution to this problem is the greater use of behavioral assessment techniques in diagnosis and treatment. Studies will be conducted to test the ability of behavior assessment techniques to increase the precision of diagnosis, estimate severity quantitatively, aid in suggesting treatment strategy, predict the course of an episode, aid in discharge and termination decisions, and indicate prodromal signs.

Although anxiolytics are widely used as adjunctive treatments in both gastrointestinal and cardiovascular disorders to reduce stress there is little research on the effectiveness of these agents in these disorders and the risk/benefit ratio associated with their use. Efforts are being made to stimulate research on the use of anxiolytics in primary medical disorders.

In addition, little is known about the relationship fo childhood anxiety disorders and adult anxiety disorders. In part, this is due to the disagreement over the classification of childhood psychiatric disorders and the lack of reliable instruments to identify and assess these disorders. Recently developed diagnostic criteria and improved assessment tools has raised the possibility that research can be conducted on the childhood anxiety disorders and their relationship to adult anxiety disorders. This possibility is being explored.

Future research will focus on co-morbidity of major forms of psychopathology with anxiety disorders, the behavioral assessment of anxiety disorders to increase precision of differential diagnosis, the relationship between childhood and adult anxiety, the cognitive and behavioral aspects of panic attacks, the psychopharmacologic treatment of anxiety disorders, and the use of anxiolytics as adjunctive treatments in cardiovascular disease and gastrointestinal disorders.

BEHAVIORAL MEDICINE AND STRESS-RELATED DISORDERS

In the past 30 years, prevention and cure of most infectious diseases has shifted the major causes of mortality and morbidity, so that chronic diseases now are the main contributors to the burden of illness in the U. S. and other developed countries. Behavioral factors are crucial in the development or management of such illnesses as cardiovascular diseases, cancers, diabetes mellitus, cirrhosis of the liver, and lung diseases as well as other leading causes of death such as accidents, homicide and suicide. Behavioral risk factors associated with these maladies include cigarette smoking, excessive alcohol consumption, illicit drug use, insufficient exercise, diets with excessive calories or salt, nonadherence to sound medical treatments, and maladaptive reactions to stress or social pressures. Statisticians have estimated that 50 percent of the mortality from the ten leading causes of death in the United States is attributable to aspects of lifestyle.

The relationship between lifestyle and disease is being demonstrated through the frightening emergence of acquired immune deficiency syndrome (AIDS). By early September 1985, 13,074 cases of AIDS had been reported to the Centers for Disease Control; 12,000 new cases are forecast for 1986. No known cure exists for this desease; over 70 percent of victims diagnosed prior to January 1983 have died. The diagnosis of AIDS presents the patient with the combined emotional liabilities associated with life-threatening illnesses and with ostracism and social isolation. The AIDS patient experiences physical and emotional depletion, depression, rejection, anxiety, death-related fears, guilt, grief, loneliness and despair. In addition, AIDS patients are at risk for psychological complications resulting from the disease process and treatment procedures. Organic brain syndromes, secondary to lymphoma of the brain; vascular problems, and lesions or central nervous system infections may present as cognitive deficits, psychosis, or motor difficulties.

NIMH began supporting research on the psychobiological and psychosocial aspect of AIDS in 1983. Progress to date includes the development, testing, and use of inventories for assessing AIDS-relevant aspects of psychosocial functioning in at-risk populations and AIDS patients. Preliminary results from one study suggest a tendency for [illegible] to be poorer than expected in at-risk individuals. Another study is conducting neuropsychological evaluations of AIDS patients to assess differences between psychological reactions to the disease and cerebral problems resulting from the disease process which may also affect mood, cognition and behavior. Other studies are looking at the psychosocial needs of people with a suspected diagnosis of AIDS, at individuals in various stages of the illness, and at changes in attitude, health practices and behaviors in persons at highest risk for developing the disease. NIMH will continue these efforts in 1987, with funds provided on a reimbursable basis, by the Office of the Assistant Secretary for Health.

In other behavioral medicine research, early results from an investigation into links between diabetes and psychopathology suggest that psychological factors do not play a significant part in determining either the status of diabetic patients or the progression of the illness and its possible complications.

A study of breast-cancer patients suggests that the stumbling block for chemotherapy compliance is the initial decision to accept the treatment rather than the ability to tolerate it once it begins. Although the initial rejection-resistance rate was relatively high (15 percent), non-compliance with chemotherapy once initiated was extremely low (5 percent). The study also found the practice of breast self-examination by breast-cancer patients to be no higher than in the general population because the exam was not perceived as a "medical" necessity and it caused anxiety in the patients. Future research will focus on ways of improving or changing perceptions of health-related behaviors.

An area of research with potentially far-reaching health implications is the disruption of the natural and biological and psychological rhythms in the body. The disruption of these natureal rhythms is believed to be related to depression, sleep disorders, and stress. Such disruptions are experienced by about 25 percent of American workers who routinely change their work shift from day to evening or night. Research is now focussing on ways of stabilizing the rhythms as a way of reducing stress and improving productivity.

An emerging area of programmatic emphasis is the role of the immune system in major mental disorders. An association between altered immunity and major mental disorders is suggested by a range of studies concerned with the role of the neuroendocrine, immune and central nervous sytems in depression and schizophrenia. Depressed patients have been shown to have significantly lower percentages of helper T-lymphocytes and significantly poorer responses to mitogen stimulation than nondepressed matched controls. Auto-immune antibodies have been found in the blood serum of schizophrenics. Psychoimmunology research is following up these exciting findings and delineating the interaction between the body's regulatory systems.

Other research areas being pursued include the behavioral factors associated with functional digestive disorders; the neurological, psychological and physiological factors involved in anorexia nervosa and bulimia; the emotional and cognitive factors in sexual dysfunction; the biomedical and behavioral aspects of obesity; and the chronobiological rhythms involved in sleep disorders.

EPIDEMIOLOGY

Epidemiology is the study of the patterns of occurrence of a disease or disorder in human populations and the factors that influence them. It is essentially a discipline of comparisons. In contrast to clinical studies of patients, which concentrate on characteristics of a disorder in individuals, epidemiology is a systematic approach to studying characteristics or risk factors of groups who have the disease. A risk factor is a characteristic associated with a particular disease that increases the probability of its occurrence. Epidemiology can make contributions to the understanding of the causes of a disorder, especially through its unique capacity to identify the first links of a causal chain.

A new era in psychiatric epidemiology dawned with the publication of the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) and the development, under NIMH sponsorship, of the Diagnostic Interview Schedule (DIS). The DIS incorporates the explicit criteria outlined in DSM-III for each illness category into a questionnaire that may be administered by lay interviewers and scored by computer. This technological development permits large scale surveys to be conducted in the community to determine rates of specific psychiatric disorders in the general population. Previously, studies were limited to small surveys or to patient populations.

The first large scale study of psychiatric disorders in the general population indicates that 19 percent of the adult population (18 years and over) have suffered a diagnosable mental disorder, including alcohol or drug abuse, in the six months prior to the survey. Only one in five of these diagnosable individuals reported any health or mental health visit related to a mental or emotion problem during that six-month period. In addition, men and women seem to have roughly similar overall rates of mental illness, but they experience specific mental disorders at different rates. Women tend to have higher rates of depression and phobias; for men, the predominant disorder is alcohol abuse and dependence. The survey also found that rates of mental disorders, with the exception of cognitive impairment, drop after age 45. Cognitive impairment, which is an approximate measurement of dementia, increased after age 65, as expected. Separation or divorce, and low socioeconomic status were found to be risk factors for most of mental disorders.

Another study has shown that the greater vulnerability of women to the emotional impact of undesirable life events is largely confined to "network" events, and is associated with the stresses inherent in the traditional role of women as care-givers. Network events are life events that occur to someone who is important in a person's social network. Women are more likely to be sought out by others as confidants, and therefore know about more network events than do men. Women also consider more people to be important to them than do men. The study concluded that this role-related difference is responsible for a substantial part of the overall relationship between gender and distress as measured by scales of depressive symptomatology. That is to say that women are more reactive to events that affect their "network" and hence exhibit more depression and anxiety.

Surveys of the mental health system covering the period from 1969-70 to 1981-82 show increases in the total number of mental health organizations, the number of additions to inpatient and residential treatment services, the number of outpatient additions, expenditures in current dollars, and the estimated number of full-time equivalent patient care staff. Decreases were noted in the number of inpatient and residential treatment beds and in the number of patients in specialty inpatient and residential treatment services.

Sample patient surveys in 1980-81 found that schizophrenia was either the most frequent or the second most frequent primary diagnosis for admission to each type of inpatient psychiatric service. Other prominent primary diagnoses were affective disorders and alcohol-related disorders. Most admissions to inpatient psychiatric care were readmissions.

A study of 1,000 homeless persons found about 30 percent of the individuals had experienced at least one psychiatric hospitalization; about 18 percent had been discharged from State mental hospitals between 1960 and 1984. Data from the Psychiatric Status Schedule indicated that about 31 percent of the total group currently required some form of mental health service.

Other research found that there has been little change in the number of adolescent admissions to inpatient psychiatric facilities during the 1970's, even though there was a decrease in the 10-14 age group in the U. S. This research also found that private psychiatric hospitals and private general hospitals are increasingly the locus for treatment of adolescents.

An analysis of NIMH data showed that from 1975-80 there has been a decrease of about 50 percent in the use of Electro-Convulsive Therapy (ECT) in inpatient facilities. The exception to the overall decrease is in public general hospitals where utilization increased. Considering a recent Consensus Development Conference which found ECT to be an effective treatment for depression, this is a trend that needs further study.

Epidemiological and service research will focus on risk factors; prevalence and incidence of mental disorders among children; procedures to estimate and project the need and demand for mental health services; mental health practices in primary care; prevalence of mental disorders in nursing homes; mental health services in community residential facilities, universities, and correctional facilities; and the economics of mental health care.

PREVENTION

Mental disorders affect one out of every five Americans, according to NIMH epidemiological studies. Lowering this rate by reducing the number of new cases is the major goal of NIMH prevention research. Three bodies of knowledge are essential to such an effort: understanding the many factors that contribute to the onset and expression of mental disorders; identifying populations at particularly high risk for such disorders; and developing, applying, and assessing interventions aimed at reducing or averting mental illness in such populations.

As part of a larger effort to study high-risk infants, one investigator is examining infants who "fail to thrive." Because this population is heterogeneous in age, chronicity, physiological and psychological status when admitted to treatment for the first time, this project is attempting to identify children within this population who are at special risk for abnormal psychological development. Another project is developing field experiments designed to use work organizations as channels for providing social support for individuals who are going through a variety of work transitions that are known to increase stress, maladaptive patterns of coping, and enduring negative health and mental health outcomes.

Another study is investigating the relationship between social support and the psychological well-being of parents and their handicapped children. The study is particularly important in that it may help us learn more about how people successfully cope with stress and adversity.

Other prevention/intervention projects in the Institute include testing prenatal prediction of child abuse and evaluating an intervention that provides high-risk mothers with social support and parenting skills training; an assessment of children who set fires, their parents and family environments to identify points of interventions; and an evaluation of a cognitive-behavioral program designed to help children at risk for antisocial behavior and related conduct disorders.

Prevention research will continue to focus on high-risk infants, children, youth, minority groups and other at-risk populations,, risk factors, pathologically stressful events, and research methodology.

INTRAMURAL RESEARCH

The NIMH intramural research program (IRP) operates some 15 laboratories and clinical branches on the campus of the National Institutes of Health, and at Saint Elizabeths Hospital. Several hundred research projects in the basic neurosciences, clinical pharmacology, clinical psychiatry, and behavioral science are conducted in these facilities each year. Roughly 70 percent of these projects have a biological focus, with integration of basic and clinical science an explicit goal.

Intramural researchers are producing new insights into the neural mechanisms of memory in primates that have important implications for understanding Alzheimer's Disease and amnesia. The researchers are proposing a model for recognition memory that involves a replication of a key circuit in the brain. According to the model, storage of the central representation of a stimulus occurs only if this pathway is activated. Damage to this pathway results in recognition failure. The model also postulates a role for the pathway in associative memory; for once stored, the stimulus can enter into association with the stored central representations of other stimuli and other events, thereby providing the stimulus with meaning. The model, however, does not account for all forms of learning and retention. At least one form, which has been labeled habit formation, remains nearly intact after parts of the limbic system have been removed. This finding suggests the existence of a powerful cortico-nonlimbic mechanism for retention of stimulus-response connections. Further development of this model will continue. This model emerged from an effort to map visual pathways in the monkey brain. In the process, researchers found that cortical tissue essential for visual perception extends far beyond the primary visual area, striate cortex, to include regions of the occipital, temporarl and parietal lobes. In addition, the multiple visual areas appear to be organized hierarchiacally into two separate cortical pathways; one coursing forward, the other backward. The forward pathway is crucial for the visual identification of objects and the cognitive association of visual objects with other events, such as emotions and motor acts. The backward pathway is critical for the visual localization of objects, the cognitive construction of spatial maps, and the visual guidance of motor acts. This pathway also appears to receive convergent input from other senses. The researchers believe memory systems for the other senses may be organized in a parallel fashion.

The mapping of the visual pathways will continue until all the stations in the system are identified. In addition, researchers will attempt to locate a "gating" mechanism which appears to be involved in selective attention; try to determine what type of information processing - sequential or parallel - is used in the pathway, examine the effects of training on the ability to distinguish between similar visual stimuli, and study the temporal code which seems to be used by neurons to store and transmit information.

Intramural researchers have discovered a high incidence of depression in the medical histories of AIDS victims, suggesting a possible vulnerability factor. They have also produced receptor maps of the sites in the brain where the AIDS virus invades neurons and documented cognitive impairments reflecting brain damage. Research on this area will expand and will continue to be conducted in collaboration with other NIH Institutes.

Limbic structures appear to make possible the cognitive association of visual objects with other events, such as emotions and motor acts. The dorsal or backward pathway is critical for the visual localization of objects; the cognitive construction of spatial maps, and the visual guidance of motor acts. This pathway also appears to receive convergent input from other senses. The researchers believe memory systems for the other senses may be organized in a parallel fashion.

Research on neuropeptides is beginning to pinpoint the intricacies involved in the intracellular regulation of neurons. Researchers have identified two peptides in the same secretory granule in chromaffin cells that are not synthesized from a common precursor, and appear to be independently regulated. Investigators also are attempting to demonstrate that while secretion and biosynthesis of secreted neuropeptides are coupled by a dependence on calcium influx, these processes are activated by cation influs through two different sets of channels that are activated and blocked under different conditions. Study of the localization of neuropeptides in the rat brain has shown for the first time that a factor found in the atrial muscle cells has a widespread distribution in the brain and suggests that it may play an important role in central cardiovascular regulatory mechanisms. This basic research on the brain is essential to understanding both normal and abnormal brain function.

Intramural researchers have also produced findings relevant to schizophrenia. Researchers in biochemical genetics have found two disease associated proteins in the cerebrospinal fluid of 32 percent of the schizophrenic patients studied, but not in manic depressives or normals. A comparison of CAT scans of 73 schizophrenic patients and 30 normal controls localized atrophy in the prefrontal area and replicated earlier findings of enlargement of lateral and third ventricles. This finding is significant because of the similarities of symptoms found in persons with known injuries of the dorsolateral prefrontal cortex and the "core" symptoms of schizophrenia including flattened affect, social impairment, apathy, and withdrawal. A further comparison of abnormalities in cerebral blood flow to structural abnormalities on CAT scans of some patients found decreased relative prefrontal blood blow correlated with prefrontal atrophy and with lateral ventricular enlargement. This seems to indicate relationships between physiological dysfunction in the prefrontal cortex and structural abrnormalities in both prefrontal and subcortical areas. The Intramural Program will pursue these findings by increasing brain imaging studies of schizophrenia.

Research indicates that caffeine, one of the more commonly ingested and potentially abused drugs, is capable of inducing panic attacks in panic-anxious patients when taken in an amount equivalent to 5 to 6 cups of coffee. It has also been discovered that alprazolam, a drug with potent effects at the "central-type" benzodiazepine receptor, blocked caffeine-induced attacks even though it did not alter many of the biochenical and neuroendocrine indices of caffeine-induced effects. Another striking finding related to caffeine is its effect on dexamethasone-induced suppression of plasma cortisol. Caffeine significantly increases plasma cortisol levels and more than doubles the percentage (14 to 36) of nonsuppressors. This data suggests the possibility that a dietary artifact such as caffeine could account for some of the differeces in dexamethasone suppression in different psychiatric populations.

Clinical studies with the newly-sequenced corticotropin releasing factor (CRF) are substantially advacing the state of knowledge concerning the pathophysiology of hypothalamic-pituitary-adrenal function. Most notably, the CRF stimulation test has helped clarify the pathophysiology of hypercortisolism in depression and Cushing's disease, and has proven useful in resolving problems with differential diagnoses. Depressed patients showed a blunted ACTH response to exogenous CRF, suggesting that the pituitary function in these patients is normal. This indicates that hypercortisolism in depression could reflect a defect at or above the hypothalamus. In addition, carbamazepine seems to interact with "peripheral-type" benzodiazepine receptors and not with "central-type" receptors. This means that the peripheral-type receptor, which has been linked to both anxiety and convulsant mechanisms in animal studies, may be a physiologically important receptor site in the brain.

Research on early adolescence shows that timing of maturation, or the age at which adolescents progress through the physical changes of puberty, is important for adjustment of adolescents. Earlier maturers may be less prepared to cope with hormone-related emotional changes, than later maturers. In addition, the research indicates that levels of hormones that rise across puberty do relate to anxiety, and aggressive behaviors in early adolescent boys, but not girls. Longitudinal analyses are planned to explore these causal issues.

Besides pursuing the research leads reported above, intramural research will emphasize studies in molecular genetics to determine the structure of genes, discover brain substances and explore the transplantation of genetic materials. In addition, the program will focus on the relationship betwen aggressive behavior and serotonin in criminal populations, the neurobiology and neuropharmacology of social behaviors in primates, and circadian rhythms in depression and manic-depressive illness.

A comparison between children of depressed parents with children from families free of psychiatric disorder found that children of depressed mothers receive more negative attributions to their self; that maternal depression was not associated with differences in social cognitive skills; that children of depressed mothers may have an attentional deficit; that children of depressed mothers have more problems of noncompliance; that frequency of expressed affection does not differ, but, depressed mothers frequently couple expressions of affection with sadness and anxiety.

Research will emphasize studies in molecular genetics to determine the structure of genes, discover brain substances and explore the transplantation of genetic materials. In addition, the program will focus on brain imaging studies in schizophrenia, the relationship between aggressive behavior and serotonin in criminal populations, the neurobiology and neuropharmacology of social behaviors in primates, and circadian rhythms in depression and manic-depressive illness.

The request for $57,493,000 reflects a net increase of $2,369,000 above the 1986 sequester level. This amount includes an increase of

$1,571,000 for mandatory items, plus a program increase for restoration of FY 1986 sequestered funds for payments to the NIH Management Fund and Service and Supply fund. Changes in funding are itemized below:

Mandatory Increases:

1. Within-grade increases......................	+$512,000
2. Increased Social Security benefits..........	+59,000
3. Increased cost of non-salary items..........	+375,000
4. Increased support costs at Saint Elizabeths Hospital Research Facility...............	+157,000
5. Increased NIH Management Fund costs.........	+313,000
6. Increased NIH Service and Supply Fund costs	+155,000
Subtotal, mandatory increases.........	+1,571,000

Program Increases:

1. Maintenance of current program level.......	+798,000
Total.................................	+2,369,000

b. Planning and Demonstrations (Section 504 of the Public Health Service Act)
1987 Authorization: Indefinite for State Planning; $20,000,000 for CSP.

Budget Authority:

1986 Appropriation	1986 Available after Sequestering	Revised Estimate 1/	1987	Increase or Decrease
$12,500,000	$ 11,962,000	$ 954,000	—	$ -954,000

1/ Excludes $11,008,000 which is proposed for rescission.

Purpose and Method of Operations: Funds under this activity operate the Institute's Community Support Program (CSP, which is a national effort to promote the development of community support systems for the long-term mentally ill), and to improve the quality and appropriateness of services and opportunitites for this population. Grant resources are also used to (1) encourage States and communities to give greater priority to the needs of this population, especially homeless mentally ill persons inappropriately living in emergency shelters, local jails, and on the streets of our cities; and (2) to mobilize States and communities to make the necessary administrative and programmatic arrangements to improve opportunities and services for chronically mentally ill people. There are two aspects to CSP:

- The adult program concentrates on those individuals who are inappropriately institutionalized in hospitals and nursing homes, and the larger number of such individuals who are living outside of hospitals without adequate housing or life support services. Awards go to State mental health agencies, which assume leadership in promoting service system improvements for the chronically mentally ill. The program also assists in developing and implementing strategies to address identified problems and gaps in meeting the needs of this patient group.

- The Child and Adolescent Service System Program (CASSP) assures the availability of a comprehensive, coordinated system of care for mentally disturbed children and youth in communities, by assisting States in assuming a leadership role and thus to promote the development of such systems of care on a State-wide basis.

The following table provides numbers of awards and funding levels displayed by type of award.

Planning and Demonstration by Type of Award

	1985 Actual		1986 after Sequestering		1986 Estimate		1987	
	No.	Amount	No.	Amount	No.	Amount	No.	Amount
State Planning:								
Noncompeting......	--	---	--	---	--	---	--	---
New..............	11	$ 2,500,000	--	---	--	---	--	---
Subtotal........	11	2,500,000	--	---	--	---	--	---
Demonstration (Community Support):								
Adult:								
Noncompeting...	35	4,670,000	35	$ 5,047,000	5	854,000	--	---
Competing......	2	268,000	--	---	--	---	--	---
New............	1	75,000	12	1,424,000	--	---	--	---
Supplemental...	(9)	720,000	--	---	--	---	--	---
Subtotal......	38	5,733,000	47	6,471,000	5	854,000	--	---
Children:								
Noncompeting...	10	1,482,000	22	3,238,000	--	---	--	---
Competing......	--	---	--	---	--	---	--	---
New............	13	1,802,000	6	814,000	--	---	--	---
Supplemental...	--	---	--	---	(1)	100,000	--	---
Subtotal....	23	3,284,000	28	4,052,000	--	100,000	--	---
Research Projects:								
Noncompeting...	5	734,000	5	1,439,000	--	---	--	---
Competing......	--	---	--	---	--	---	--	---
New............	3	747,000	--	---	--	---	--	---
Supplemental...	--	---	--	---	--	---	--	---
Subtotal....	8	1,481,000	5	1,439,000	--	---	--	---
Total Demonstrations.	69	10,496,000	80	11,962,000	5	954,000	--	---
Total Planning and Demonstrations.....	80	12,998,000	80	11,962,000	5	954,000	--	---

Rationale for the Budget Request:

The budget includes proposals to rescind funds appropriated for the Community Support Program this year, and phase out the program in 1987. The Community Support Program was initiated in 1977 under the demonstration authority of Section 301 of the Public Health Service Act. The program was initially intended to be a demonstration of limited duration, and cover a limited number of States which would share results with other States. We have now gone beyond the original scope of the program and funded adult programs in all 50 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands. The children's program, started in 1984, will have provided at least two years of demonstration experience.

c. Protection and Advocacy (Authorizing legislation pending)

1987 Authorization: Not authorized

Budget Authority:

1986 Appropriation	1986 after Sequestering	1986 Revised	1987	Increase or Decrease
$10,000,000	$9,570,000	---	---	---

Purpose and Method of Operations: The intent of this program is to ensure that the established rights of hospitalized mentally ill persons are protected and to help States establish and operate protection and advocacy systems to (a) protect and enforce established rights; and (b) investigate reports of abuse and neglect. States would be eligible for support under this program if they have existing systems to protect and advocate the rights of persons with developmental disabilities under Part C of the Developmental Disabilities Assistance and Bill of Rights Act.

Rationale for the Budget Request: In 1986, Congress appropriated $10,000,000 for this program and stipulated that the availability of these funds was contingent upon the enactment of authorizing legislation. To date, the legislation has not been enacted, although there are separate bills in the House (HR 4055) and Senate (S-974). The budget request includes a proposal to rescind any funds which would become available in 1986. No funding is requested in 1987. The program would duplicate the States' capacities to protect mentally ill persons from abuse and neglect. The Administration believes that States have the capacity to monitor care of the mentally ill.

d. Training (Sections 303 and 472 of the Public Health Service Act)
1987 Authorization: Indefinite for Section 303; authorization of $260,000,000 for Section 472, which is shared with NIH.

Budget Authority:

1986 Appropriation	1986 Available after Sequestering	Revised Estimate 1/	1987	Increase or Decrease
Clinical Training: $20,000,000	$ 19,140,000	—	—	—
Research Training: 18,000,000	17,225,000	$17,225,000	$ 15,847,000	$ -1,378,000
38,000,000	36,365,000	17,225,000	15,847,000	-1,378,000

1/ Excludes $19,140,000 which is proposed for rescission.

Purpose and Method of Operations -- The purpose of the training program is to assure an adequate, balanced, and properly distributed supply of mental health service providers and a steady flow of researchers prepared and motivated to conduct mental health research; and to match training and skills with identified national needs and priorities.

Clinical Training

The clinical training program accomplishes its mission by awarding grants for the education of personnel to deliver mental health services, and for the development of State manpower systems. Awards are made to public or non-profit private institutions to train personnel to deliver services to specifically designated underserved areas and populations (children, the elderly, minorities, and the chronically mentally ill), to increase the supply of minority service providers, and to work to prevent mental illness. All graduate trainees in the disciplines of psychiatry, psychology, nursing and social work who receive stipend support through these grants for six months or more must pay back this support through a period of service in shortage areas or to underserved populations. The State manpower development program provided support to States to assist them in planning, problem identification and systems development regarding staff in public facilities.

Research Training

The goal of the mental health research training program is to assure a continuing and adequate supply of well-trained personnel who are able to conduct research on mental health problems. The program consists of the provision of training grants to institutions and fellowships to individuals, at both the predoctoral and postdoctoral levels. In addition, there are special programs targeted toward minorities. Awards are made for training in the areas of basic biomedical, clinical, and behavioral research; the epidemiology of mental disorders; their etiology description, diagnosis and pathogenesis; treatment development, assessment and evaluation; public health intervention and prevention approaches; and programs designed to increase the supply of minority mental health research scientists trained to work in the above areas. Students receiving NIMH fellowships or stipend support under institutional awards are obligated to pay back this support through a period of research and/or teaching activities after the completion of their training. The various areas of research training are described more fully below:

Basic Biomedical and Behavioral Processes:

A thorough education in the techniques, methods, and content of the biomedical and behavioral sciences is essential to the mental health researcher. At a time when new knowledge in the area of neurosciences and behavioral sciences is expanding rapidly, training in the basic biomedical and behavioral processes, with special attention to mental health issues, is essential to the advancement of the field. Research training is especially encouraged in the areas of molecular biology molecular genetics, brain imaging technology, and the interrelationships between brain functions, neuroendocrine function, immune functions, and behavior.

Incidence and Prevalence:

The goal of training in this area is to increase the number of epidemiologists and biostatisticians specializing in the mental disorders and to provide training in epidemiologic principles to mental health professionals. Both epidemiology and biostatistics have been designated as shortage areas by the National Research Council, and specialists in the mental health area are even more rare. The training of clinical epidemiologists is particularly stressed.

Etiology of Mental Disorders:

This area of training prepares individuals to do research on the biological, psychological and the environmental causes of mental disorders and on factors which are conducive to mental health. Training may be in the genetics of serious disorders, such as schizophrenia, affective disorders, anxiety disorders, attentional deficit disorders, suicide, impulse control disorders, the neurochemical systems underlying them, the consequences of stress in the workplace, or the effect of the environment on child development.

Development, Assessment, and Evaluation of Treatment:

Trainees in this area are prepared to do research on pharmacological, psychological, behavioral, and environmental therapies. They must learn to master and develop techniques of measuring the different mental disorders in children, adolescents, adults, and the aging, gain a thorough knowledge of the relevant treatments, and study how to evaluate the efficacy and feasibility of each type of treatment.

Public Health/Prevention:

The goal of this area is to prepare researchers to design and evaluate interventions that can prevent the onset of mental illness or retard its growth. Research in the etiology of mental illness has shown that some individuals are at greater risk for psychopathology than others. Critical goals of the NIMH research and research training programs include (1) identification of risk factors and their relative contributions to the expression of an illness; (2) finding the protective factors that increase resistence to psychopathology; (3) development of effective strategies of preventive intervention; and (4) development of a research capability to foster clinical services and services systems designed to improve the mental health service delivery system. This training brings a system perspective to issues such as cost and financing of mental health services, assessment of need, efficacy, appropriateness and quality of care, evaluation of patient outcomes in different settings, and system impacts. It requires the combining of prevalence and incidence data with service utilization data and data on the availability of facilities and services. Many of the trainees in this program work with NIMH data or are involved in NIMH-funded research projects.

Minority Mental Health:

Other grants and fellowships are also awarded for the training of minority mental health researchers. The major components of the ADAMHA's minority research training effort are the Minority Fellowship and the Minority Access to Research Careers (MARC) programs. The shortage of minority researchers trained in problems relevant to mental health is well documented and longstanding. Although they comprise approximately 19 percent of the U.S. population, Blacks, Hispanics, and American Indians were awarded only seven percent of all doctorates in 1984. More specifically, they received three percent of the doctorates in the biological sciences and seven and a half percent of those in the social sciences. The percent of minorities is even lower in the general researcher pool, since recent efforts have increased the number of new minority doctoral recipients.

The Minority Fellowship Program provides assistance to minority students to receive training for research careers in mental health. Grants are awarded to major mental health professional associations who recruit and identify outstanding minority students in their disciplines and provide them, through the grant, stipend and tuition support while they are pursuing their doctoral studies.

The ADAMHA MARC program, for which NIMH has the lead responsibility, is intended to assist institutions with substantial minority enrollment in preparing students for graduate study in the alcohol, drug abuse, and mental health fields. In addition, Faculty Fellowship awards support minority faculty for advanced training so that they may return to their home institutions to teach and conduct research, and to serve as role models.

Levels of clinical and research training support are set forth on the following table. After this table, amounts allocated by discipline and program area are shown, as well as numbers of research trainees at the predoctoral and postdoctoral levels.

Training by Type of Award

	1985 Actual		1986 after Sequestering		1986 Revised 1/		1987 Estimate	
	No.	Amount	No.	Amount	No.	Amount	No.	Amount
Clinical Training:								
Grants:								
Noncompeting.....	387	$15,867,000	126	$ 5,072,000	--	---	--	---
Competing........	1	365,000	1	62,000	--	---	--	---
New..............	37	1,330,000	160	9,150,000	--	---	--	---
Supplemental.....	--	---	--	---	--	---	--	---
Subtotal.......	425	17,562,000	287	14,284,000	--	---	--	---
State Manpower Development:								
Noncompeting.....	30	2,914,000	22	2,389,000	--	---	--	---
Competing........	6	744,000	8	750,000	--	---	--	---
New..............	3	271,000	7	759,000	--	---	--	---
Subtotal.......	39	3,929,000	37	3,898,000	--	---	--	---
Contracts: 2/								
New..............	5	507,000	9	958,000	--	---	--	---
Total Clinical Training........	469	21,998,000	333	19,140,000	--	---	--	---
Research Training:								
Grants:								
Noncompeting.....	127	12,913,000	108	10,716,000	108	10,716,000	111	11,322,000
Competing........	19	1,758,000	20	20,841,000	20	2,084,000	11	1,150,000
New..............	9	834,000	16	1,766,000	16	1,766,000	8	923,000
Supplemental.....	(2)	195,000	(2)	75,000	(2)	75,000	(1)	75,000
Subtotal.......	155	15,700,000	144	14,641,000	144	14,641,000	130	13,470,000
Fellowships:								
Predoctoral:								
Noncompeting.....	34	300,000	41	360,000	41	360,000	36	377,000
New/competing....	32	336,000	26	339,000	26	339,000	25	263,000
Subtotal, Predoctoral.....	66	636,000	67	699,000	67	699,000	61	640,000
Postdoctoral:								
Noncompeting.....	21	501,000	33	1,246,000	33	863,000	25	677,000
New/competing....	44	1,161,000	39	639,000	39	1,022,000	29	1,060,000
Subtotal, Post doctoral.....	65	1,662,000	72	1,885,000	72	1,885,000	64	1,737,000
Subtotal, Fellowships..	131	2,298,000	139	2,584,000	139	2,584,000	125	2,377,000
Total Research Trng...	286	17,998,000	283	17,225,000	283	17,225,000	255	15,847,000
Total Training........	755	39,996,000	616	36,365,000	283	17,225,000	255	15,847,000

1/ Excludes $19,140,000 which is proposed for rescission.

2/ FY 1985 includes $250,000 for four contracts to train personnel in the recognition of alcohol and drug abuse problems and $257,000 for one reimbursable agreement with the Rehabilitation Services Administration for joint training for services to chronically mentally ill and developmentally disabled children. FY 1986 appropriation after sequestering reflects nine contracts relating to drug and alcohol abuse training.
and alcohol abuse training.

64

Clinical Training Program Distribution

	1985 Actual		1986 Available after Sequestering		1986 Revised 1/		1987	
	No.	Amount	No.	Amount	No.	Amount	No.	Amount
Total Program:								
Mental Health Manpower R&D	41	$ 3,255,000	15	$ 1,553,000	--	---	--	--
State Manpower Development	39	3,929,000	37	3,898,000	--	---	--	---
Mental Health Service Education:								
Psychiatry..............	62	5,763,000	86	3,480,000	--	---	--	-
Nursing..................	44	2,279,000	46	2,583,000	--	---	--	-
Social Work..............	80	2,992,000	65	3,085,000	-	---	--	---
Psychology...............	92	3,026,000	71	3,436,000	--	---	--	---
Paraprofessional.........	6	247,000	4	147,000	--	---	--	-
Other A/.................	5	507,000	9	958,000	--	---	--	-
Total....................	469	21,998,000	333	19,140,000	--	---	--	-
New/Competing:								
Mental Health Manpower R&D	11	891,000	11	1,316,000	--	---	--	---
State Manpower Development	9	1,015,000	15	1,509,000	--	---	--	---
Mental Health Service Education:								
Psychiatry...............	3	94,000	36	2,021,000	-	---	--	---
Nursing..................	2	73,000	37	1,963,000	--	---	--	---
Social Work..............	9	261,000	37	1,916,000	--	---	--	---
Psychology...............	13	375,000	40	1,996,000	--	---	--	--
Paraprofessional.........	--	---	--	---	--	---	--	--
Other A/.................	5	507,000	9	958,000	--	---	--	---
Total....................	52	3,216,000	185	11,679,000	--	---	--	--

The number of trainee full-time equivalents (FTEs) supported by the research training program is as follo

	1985	1986	1987
Institutional Awards:			
Predoctoral..............	403	360	348
Postdoctoral.............	357	329	289
Subtotal...............	760	689	637
Fellowships:			
Predoctoral..............	60	61	56
Postdoctoral.............	59	66	58
Subtotal...............	[illegible]	127	114
Totals:			
Predoctoral..............	463	421	404
Postdoctoral.............	416	395	347
Total....................	879	816	751

A/ Includes $250,000 for four contracts to train personnel in the recognition of alcohol and drug abuse problems, and $257,000 for one reimbursable agreement with the Rehabilitation Services Administration for joint training for services to chronically mentally ill and developmentally disabled children. FY 1986 reflects nine additional contracts relating to drug and alcohol abuse training.

Rationale for the Budget Request:

Clinical Training

The 1986 and 1987 budgets incorporate a proposal to phase out all Federal support for the training of personnel in the mental health professions and related fields. Ongoing programs will receive their final year of funding in 1985. When the NIMH clinical training program was established 35 years ago there were only 5,000 psychiatrists in the country and most medical schools did not have independent departments of psychiatry. The profession of clinical psychology was in its infancy and there was no graduate level specialty in psychiatric nursing. Social work had not developed a focus on mental health. NIMH support was instrumental in building academic mental health training departments, improving the quality of training, and greatly increasing the numbers of mental health professionals. For example:

- Today there are over 31,000 psychiatrists, including 3,200 child psychiatrists;
- There are now approximately 7,000 psychiatric nurses and the field has status as a recognized profession.

To ensure that individuals were trained in fields which meet national service delivery needs, NIMH began a major redirection of its clinical training activities in the mid 1970's with the result that today increasing numbers of trained personnel serve in public facilities, provide service to the chronically mentally ill, and are available to treat special population groups such as minorities, the aged, and children. The clinical training program has shaped and built the national training capacity to the point that the training community will continue to function productively without Federal support.

Research Training

The types of research training which will be particularly stressed in FY 1987 will include preparation for research on schizophrenia, the etiology and treatment of mental disorders in children, molecular genetics, the neurobiology of aging and mental diseases of the elderly, support systems for the elderly which can help reduce psychological debility, and research on psychoneuroimmunology, including its relevance to AIDS. All of these areas are characterized by rapid growth and shortages of well-trained researchers. This shift of emphasis will take place within a trainee level of 751, representing a decrease of 65 below the current level after sequestering. Approximately 54 percent of the trainees supported will be at the predoctoral level in 1987.

The level of support per trainee, for both stipend and non-stipend support, will be maintained at the 1986 level.

e. Direct Operations (Section 301 of the Public Health Service Act)
1987 Authorization: Indefinite

Budget Authority:

	Appropriation	[illegible] after Sequestering	1986 Revised 1/	1987	Increase or Decrease
Dir. Ops....	$ 34,675,000	$33,184,000	$31,836,000	$31,749,000	-$87,000
FTEs			364	364	---

1/ Excludes $1,348,000 in project activities related to AIDS, which are comparably transferred to the Office of the Assistant Secretary for Health. NIMH staff will continue to administer this program in 1987, on a reimbursable basis.

Purpose and Method of Operations - The purpose of this program is to support the staff who are responsible for the planning, development and administration of the grants and contracts programs under the research and training activities. Also included are staff charged with general oversight of the operation of Saint Elizabeths Hospital.

The staff supported under this activity provide consultation to research grant applicants, organize research conferences, and coordinate research efforts through cooperative agreements. In addition to these support functions, the staff are responsible for program development activities, relating to major national initiatives in such diverse fields as prevention, teenage suicide, special problems of children and the elderly, and Acquired Immune Deficiency Syndrome (AIDS). The staff also support other ongoing Federal responsibilities, including:

- Collecting and exchanging statistical data and non-statistical information;
- Disseminating knowledge;
- Providing professional and technical consultation to States, and specific public and private organizations, at their request; and
- Fostering collaboration between the public and private sectors.

This activity supports the Institute's National Reporting System which gathers, on a continuing basis, timely data relating to incidence and prevalence of mental illness throughout the U.S. Conferences and workshops are supported, which provide for the exchange of information among mental health professionals throughout the field. An extensive effort is made to promote activities relating to the prevention of mental illness, and to removal of the stigma which continues to cause personal and economic hardships for those who have been cured of mental illness.

Rationale for the Budget Request:

Budgetary changes in 1987 are limited to normal cost of living increases. The request for $32,923,000 reflects a net decrease of $87,000 below the 1986 current estimate. Changes in funding are itemized below:

Mandatory Increases:	
Within grade increases	+$341,000
Increased FTS costs	+11,000
Increased payments to Federal Employee Compensation fund	+25,000
Increased Social Security benefits	+40,000
Increased cost for non-pay items	+591,000
Subtotal, mandatory increases	+1,008,000
Mandatory Decreases:	
Reduction for Service and Supply Fund	-36,000
Reduction for Standard Level User Charges	-82,000
Subtotal, mandatory decreases	-118,000
Program Decreases:	
Reduction for administrative overhead	-858,000
Program decreases	-119,000
Subtotal, program decreases	-977,000
Total, net change	-87,000

II. DRUG ABUSE

	1986 Appropriation	1986 Available after Sequestering	1986 Revised Estimate 1/	1987	Increase or Decrease
Research	$74,000,000	$70,817,000	$65,236,000	$67,405,000	+$2,169,000
FTEs			85	85	---
Training	1,500,000	1,436,000	1,436,000	1,355,000	- 81,000
Dir Ops	16,307,000	15,606,000	13,816,000	14,183,000	+ 367,000
FTEs	177		175	175	---
Total	$91,807,000	$87,859,000	$80,488,000	$82,943,000	+$2,455,000
FTEs			260	260	

1/ This column excludes $11,319,000, of which $7,107,000 is a comparable transfer of Priority Disease Control and Research Projects (AIDS) to the Office of the Assistant Secretary; $264,000 is required to be withheld by Section 515 of the Treasury, Postal Service, and General Government Appropriations Act, 1986; and, $3,948,000 is required to be reduced pursuant to the Balanced Budget and Emergency Deficit Control Act of 1985, P.L. 99-177.

Narrative

The National Institute on Drug Abuse (NIDA) is the lead Federal agency responsible for improving the nation's ability to prevent and treat drug abuse. To accomplish this mission, NIDA sponsors research on the causes and consequences of drug abuse, collects information on the incidence and prevalence of drug abuse, and provides assistance to other Federal agencies, State and local governments, private organizations, and the public in their efforts to prevent and treat drug abuse.

The current high levels of illicit drug use in the United States reflect the dramatic increases in illicit drug use that occurred between 1960 and 1979. The "drug epidemic" of the 1960s and 1970s was not the first in our history, but it was in many ways unique. It was not, for example, limited to specific population groups as most previous epidemics were. Although there were geographical and ethnic differences in patterns of use, the increase in drug use in the 1960s and 1970s occurred across virtually all population groups in the United States. Currently, about one third of the household population has tried an illicit substance. Another difference was that the variety of substances abused increased at an unprecedented rate. Before 1960, an inventory of the most frequently abused substances might have included a dozen drugs. Since then, we have seen major increases in the illicit use of licit, psychoactive therapeutic drugs as well as the introduction of new illicit drugs. This year, the standard reports of the Drug Abuse Warning Network are limited to the top 50 substances which are abused by sufficient numbers of people to make it important to collect information on their adverse consequences. Another difference involved social attitudes toward drug use. While it was certainly not universal, there was widespread tolerance of so called "recreational" drug use among many influential groups in the population which, if it did not encourage drug use, certainly did not discourage it. Finally, and perhaps most important, it was an epidemic which fell disproportionally on the young. In 1962, only about one percent of the entire population had ever tried any illicit substance. By 1979, 60 percent of high school seniors had tried marijuana.

This epidemic has had a lasting effect on patterns of drug use in the United States and our concerns about drug use. While the epidemic peaked in 1979, many experts believe that drug use in the United States remains at levels higher than those found in any other industrialized nation. Drug use now starts at the high school level, if not sooner, and continues through all age ranges. While the abuse of narcotics remains a serious problem, it now competes for attention with the problems posed by the use of marijuana, cocaine, PCP, so called "designer drugs," as well as illicitly used stimulants and sedatives. While we remain concerned over the effects of drug use on the user, this concern has been tempered by the realization that it is not only the drug user who is affected by drug abuse. Concern over the relationship between drug use and crime, the effect of drug use on safety in the workplace and on the highways, the effects of drugs on the offspring of drug using parents, and, more recently, about the role of drug use in the spread of Acquired Immunodeficiency Syndrome (AIDS) have all emerged as major national issues.

As our recognition of these problems grew over the last twelve years, our attitudes toward drug use have hardened. The "permissiveness" of the 1960s has been replaced by a growing intolerance of drug use. Groups of private citizens such as the Federation of Parents for Drug Free Youth and Mothers Against Drunk Driving have formed to actively combat drug abuse in their communities. Private companies have organized programs to prevent and treat drug abuse among their employees. The willingness of private citizens to organize in the fight against drug abuse has been one of the most encouraging developments of the 1980s. In a time of increasing fiscal austerity, the willingness of private individuals to devote large amounts of time and resources offers the promise of continued progress in the fight against drug abuse. One of NIDA's highest priorities in FY 1987 will be to assist private groups in their efforts. As it has in the past, NIDA will offer its services to help grassroots movements develop in communities, to aid in the development and operation of school-based prevention programs, and to help private businesses set up drug abuse prevention and treatment programs for their employees. Modest efforts in these areas provide great payoffs in the near future.

The changes we have noted in the variety of drugs being abused and the extensive involvement of the young in drug abuse have prompted changes in the direction of our research efforts. In the early 1970s, when NIDA was established, we were in the midst of a heroin epidemic for which the Nation was almost totally unprepared. The majority of our efforts, naturally, directed toward narcotic abuse. Tremendous progress was made. Through our service programs in the 1970s and early 1980s, the Nation's capacity to treat drug users was increased dramatically. Our research program produced a series of major breakthroughs including the discovery of endogenous opiates and receptors, the development of new drugs for the treatment of narcotic abuse, and major improvements in therapies for narcotic addicts. Yet, as our successes were increasing, the nature of drug abuse was changing. In recognition of these changes, there has been a gradual shift of emphasis in our programs to meet these new problems. Over the next few years this movement will continue, with major emphasis being placed on three major problems.

Cocaine has become the drug of choice for an ever increasing number of Americans. As its use has become more common, so has the realization of its dangers. Because it has not been widely used until recently, comparatively little research has been done on cocaine or the treatment of cocaine abuse. Over the next several years we will make major efforts to increase our understanding of how cocaine affects the brain, to clarify the health and behavioral hazards associated with various forms of cocaine use, and to develop effective treatment regimens for cocaine users. In this effort, the knowledge we have gained over the last twelve years in our research on narcotic abuse will serve as an invaluable base which will save us many years of effort.

As more and more adolescents have entered the drug abuse treatment system, it has become clear that many of the treatment techniques that work well with older narcotics users are not so effective in the treatment of adolescent, non-opiate drug users. The development of effective treatment programs for this population is, therefore, especially important and will be a high priority for a number of years. One line of research that appears especially promising will build upon findings that show a strong relationship between various kinds of antisocial behavior and drug abuse. These findings suggest that it may be possible to identify, at fairly early ages, individuals who are at great risk of developing patterns of antisocial behavior, including drug abuse, and to develop programs to either prevent or intervene in what would otherwise be a steady progression toward increasing drug use and crime. A pilot study along these lines is now underway in the intramural program of the Institute.

Finally, the growing number of people seeking treatment for drug abuse is placing an increasingly heavy burden on the Nation's treatment system. Over the last twelve years we have supported research on the effectiveness of various ways of treating drug abuse. As a result of this research, we now know, by and large, which programs work with various kinds of drug users and which ones do not, and this information has been widely disseminated to the drug abuse treatment field. We are not so knowledgeable, however, about the cost effectiveness of various kinds of treatment. This is increasingly an area of concern to both public and private providers of drug abuse services who must operate under varying degrees of fiscal constraints. We intend to focus greater attention on this question over the next several years, in part by redirecting some of our current treatment research into this area, and in part by the addition of new funds. We hope soon to be able to advise treatment programs not only on the effectiveness of various treatment techniques, but also on the cost benefits of various treatment approaches.

A. Drug Abuse Research
(Public Health Service Act, Section 301)

Budget Authority : Indefinite for Section 301.

	1986 Appropriation	1986 Available after Sequestering	1986 Revised Estimate 1/	1987	Increase or Decrease
Research	$74,000,000	$70,817,000	$65,236,000	$67,405,000	+$2,169,000
FTEs			85	85	--

1/ This column excludes $8,764,000, of which $5,317,000 is a comparable transfer of Priority Disease Control and Research Projects (AIDS) to the Office of the Assistant Secretary; $264,000 is required to be withheld by Section 515 of the Treasury, Postal Service, and General Government Appropriations Act, 1986; and, $3,183,000 is required to be reduced pursuant to the Balanced Budget and Emergency Deficit Control Act of 1985, P.L. 99-177.

Purpose and method of operation - The National Institute on Drug Abuse (NIDA) is the lead Federal agency responsible for supporting research on drug abuse. Research is supported extramurally through grants and contracts, and intramurally at the Addiction Research Center in Baltimore, Maryland.

In the last year, NIDA has made progress across a broad spectrum of our research portfolio - from advances in our understanding of how drugs act on the brain to improvements in our ability to treat drug users. The following are a few of our most important findings.

Last year we reported a finding by one of our grantees that high doses of methamphetamine could produce degeneration of dopaminergic nerve terminals resulting in permanent brain damage. Work performed during the last year has clarified the nature of this process and demonstrated that it is not an isolated phenomenon. When a cell containing the neurotransmitter dopamine is stimulated, it releases dopamine into the synaptic cleft between it and adjoining neurons. Some of the dopamine binds to receptors on the adjoining cell. That which does not bind to receptors is inactivated by a recycling process in which it is reabsorbed by the cell for reuse. Under normal conditions, a very small amount of the dopamine is not reabsorbed, but is changed into another substance, a neurotoxin. Because this last effect occurs on such a small scale, it normally has little effect. Methamphetamine has been found to block the reabsorbtion of dopamine back into the cell. As a result, abnormally large amounts remain in the synaptic cleft, and abnormally large amounts of the neurotoxin are produced. This neurotoxin then attacks the dopamine cell terminals, causing their destruction. It has also been found that methaphetamine and another drug commonly known has MDA, can induce the destruction of serotonin terminals in the brain through a similar process.

These observations are important for two reasons. First, very little is known about these naturally occurring neurotoxins, including their role in the brain and whether they are formed normally in the brain in potentially toxic amounts. Second, they raise new questions about the dangers resulting from the abuse of amphetamine and related drugs, possibly including cocaine. In particular, they raise a serious concern that the abuse of these drugs may result in permanent brain damage or combine with the aging process to produce neurological disease.

We also reported last year on progress on determining the circuits in the brain involved in reward and the effects of drugs on them. One of the findings we mentioned was a study which indicated that both opiates and cocaine act directly, although through different routes, on this circuitry by stimulating the release of the neurotransmitter dopamine in the ventral tegmental area of the brain. Part of this research involved comparing the effects of narcotics and cocaine by analyzing existing data from different laboratories. What was found from this analysis was that cocaine is apparently more rewarding than narcotics in that the animals being studied would work for cocaine much more vigorously than they would for narcotics. In fact, the animals given unlimited access to cocaine would use it rather than eat, sleep, or engage in sex, until they died from cocaine overdose. On the other hand, animals given unlimited access to a narcotic would use it heavily, but would modulate their intake so that other activities were not disrupted. This analysis ran so counter to popular and scientific belief that we felt it necessary to replicate it under more controlled conditions. Again it was found that animals given unlimited access to cocaine would use it rather than eat or drink water, with the result that they died within four weeks. This study provides further confirmation of the reinforcing power of cocaine. We know of no other drug which results in such compulsive use, when freely available, as to lead to death. Cocaine may well be the most dangerous drug we know of today.

Progress has also been made within the last year on understanding the genetic regulation of endogenous opiate peptides. While research on opiate receptors and peptides has been a major part of NIDA's research program since they were discovered by NIDA grantees twelve years ago, it has only been in the last year that the genes that code for the chemical precursors from which the opiate peptides derive have been identified. The biologically active opiate peptides that we have been most concerned with are derived from larger precursor molecules which are broken apart by enzymes. The identification of the genetic codes for these precursors has made it potentially possible to clone the DNA responsible for these precursors and determine their chemical structure. Work has also begun on identifying the enzymes involved in this process and their genetic codes.

This research has enormous potential for increasing our understanding of the endorphin system. For example, the chemical structure of certain endopeptidases (enzymes which act on endorphin peptides) have been determined. These enzymes reside in the pituitary lobes that synthesize proendorphin molecules. NIDA investigators have successfully incorporated the gene that codes for the endorphin precursor peptide, pro-opiomelanocortin, into isolated cultured pituitary cells so that they can now study this whole system in one unique and rapidly reproducing cell line.

Over the last several years a growing body of evidence has been collected indicating that drug use may produce detrimental effects on the immune response system. More recently, concern over AIDS has heightened interest in this area. Recent studies by NIDA grantees have demonstrated that microbial infections in animals are exacerbated by THC, the major active ingredient in marijuana. Guinea pigs, for example, are sensitive to infection by the herpes simplex virus type 2 (HSV-2) and develop vaginal herpes similar to the human disease. Animals treated with THC had an increased incidence of lesions and mortality. In another study involving mice, delta-9-THC was shown to reduce host resistance to viral infections by suppressing alpha and beta interferon production. The mechanisms for this increased susceptibility are not known, although the suppression of a variety of components of the immune system has been implicated.

A growing problem in recent years has been the development and distribution of so-called "designer drugs." The term "designer drugs" is generally used to refer to synthetic analogs of various substances produced by making minor structural changes in known compounds. Because of these structural changes, which do not eliminate the psychoactive effects of the drug, these drugs are not legally considered controlled substances, and can be produced without fear of prosecution. They are exceptionally dangerous for three reasons. First, they share many of the dangerous properties of the psychoactive drugs to which they are related. Second, the structural changes may result in harmful effects not present in the original drug. For example, three years ago a fentanyl analog sold on the street as "China White" resulted in the deaths of a number of narcotic addicts because the small structural change made to the fentanyl molecule considerably increased the potency of the compound and overdose became much more likely. More recently a similar analog of fentanyl (3-methylfentanyl) has appeared on the street which is more potent than fentanyl. Third, they are often contaminated with harmful by-products. For example, preparations of a synthetic heroin which is an analog of meperidine is known to be frequently contaminated with a by-product of the synthesis capable of producing parkinsonism after only two or three injections.

Under current law, the DEA can issue an emergency schedule for newly identified synthetic drugs with apparent abuse potential, but cannot, in general, permanently schedule the drug without confirmation of the drug's abuse potential. NIDA assists the DEA in the process by synthesizing pure standards of the street drugs and then testing them for abuse liability and toxicity as well as conducting basic pharmacological research. In six months we have done this work on 13 synthetic drugs.

Legislation currently pending in the Congress will reduce the magnitude of this problem by making it illegal to synthesize analogs of controlled substances. However, it is still likely that more and more of these compounds will appear on the street in the future. Because they can be made cheaply, they offer street chemists a way of obtaining illicit drugs without the expense and danger involved in smuggling drugs. There will continue to be a need for a rapid means to prepare purified versions of the analogs, test them for their toxicity and abuse potential, and perform research on them.

Over the last twelve years NIDA has invested considerable effort in research on the evaluation of various drug abuse treatment modalities. As a result of this research, we now have a much better understanding of the effectiveness of various treatment approaches. In recent years, building on this knowledge, we have placed greater emphasis on evaluating not only the effectiveness of treatment, but the cost-effectiveness of various treatment approaches. In the last year we have published many of the findings of this research in a NIDA research monograph Short Term Cost Effective Treatment Strategies. This monograph describes several treatment approaches that have been demonstrated to be effective and are considerably less costly than many traditional treatment regimens. For example, recent research indicates that both cognitive behavior therapy and psychotherapy improve treatment outcome for seriously depressed methadone maintenance clients over traditional drug-abuse counseling. The addition of psychotherapy to the normal treatment regimen may actually reduce program costs by speeding the treatment process and preventing relapse. Family therapy approaches have also been found to be beneficial in the treatment of drug abuse patients, particularly adolescents. The use of family therapy techniques has been found to reduce drug use, psychopathology, and to strengthen family structure.

Another accomplishment in the area of treatment research has been the development of effective treatment programs for cocaine users. Until very recently there were no generally recognized effective treatment programs for cocaine users. Recently, however, behavioral intervention strategies based on contingency contracting methods have been shown to be effective. For example, drug abusing physicians struggling to maintain a drug-free condition are three times as successful when they have arranged to have their licenses revoked at the first relapse. This arrangement is made by a formal contract with another health care professional, who monitors the physician's drug use and holds a letter from the physician to the State licensing board requesting license revocation, should monitoring reveal a relapse. This technique has been effective with individuals who represent the more affluent drug members of the drug abusing community, including physicians, dentists, and nurses. There has been substantial emphasis on integrating this strategy with other approaches and using it for other populations using other drugs.

Other recent findings in the area of treatment research show that environmental factors play a major role in a formerly addicted individual's ability to remain drug free. For example, deliberately exposing a detoxified addict to the environment in which he had used drugs can trigger a classic drug withdrawal reaction. The implication of these findings is that for treatment to be successful over the long term, steps must be taken to isolate former drug users from environmental situations which might result in relapse. In the last year, a NIDA grantee has shown that the use of hypnosis can be an effective way of providing this isolation, not by physically removing the former drug user from his environment, but by essentially innoculating them against the effects of the environment.

The development of techniques for collecting reliable and timely information on levels and patterns of drug use has been one of NIDA's major accomplishments. Over the last year significant progress has been made in improving the techniques used in one of our most important survey tools, the National Household Survey. This year's survey will be the largest ever conducted and will, for the first time, contain an oversampling of Black and Hispanic households. The information gathered by this survey, which should be available in March 1986, will make it possible to develop reliable estimates of the use of drugs in black and Hispanic households as well as in the population at large.

Data from three of NIDA's major data collection programs: the Drug Abuse Warning Network (DAWN), the Household Survey, and the High School Senior Survey have been used by NIDA researchers to investigate a number of questions over the last year. One of the most important of these has been to more accurately determine trends in the use of cocaine. For example, it had been suspected that the increases noted in the numbers of cocaine users over the age of 25 was not due to increased numbers of people using drugs, but rather to the aging of a population group that began drug use in the 1960s and 1970s. The analysis performed by NIDA staff revealed that this is not entirely correct. It demonstrated that a significant portion of individuals over the age of 25 actually began their drug use after reaching this age. This finding has important implications for cocaine prevention programs. The study also revealed that new cocaine users in this age group were more likely than the general population to be unmarried, employed, college graduates, living in a metropolitan area, and in the western United States. This information will also be used in the development of cocaine prevention programs.

The three data collection programs mentioned above: DAWN, and the Household and High School Surveys, form the backbone of our data collection activities. They are, however, very expensive. Over the last several years NIDA has explored ways of obtaining similar data in less expensive ways. For example, in 1985 questions were added to a Gallup Poll on alcohol, marijuana, and cocaine use to assess whether this type of survey could be used to obtain reliable data. Another technique being studied is the use of telephone surveys to collect information on drug use, attitudes, trends, and other issues. This study is being coordinated with the Centers for Disease Control to evaluate the addition of these types of questions to the Behavioral Risk Factors Telephone Surveillance System. Should these techniques prove acceptable, it will be possible to make our data collection efforts much more timely and to expand them at relatively little additional cost to populations not currently covered.

Rationale for the Budget Request

The research project grant budget for NIDA in 1987 allows its portion of the agency's new total ceiling of 1,400. The number is slightly higher in 1986 because the agency total is 1,408 in that year. Agency funding for the research project grants is predicated on the provision of a 4 percent growth in total average grant costs in 1986 and again in 1987 over the 1985 total actual average cost. However, in the case of NIDA, its total research authorization level of $74,000,000 (including AIDS funds transfer to OASH) precluded its participation in this increase in 1986. The 4 percent increase in 1987 is for direct costs only. Some savings have been calculated in line with the reduction of "administrative costs" portion of indirect costs in 1987 which reduce the total growth from 4 percent in that year.

Extramural Research	1985 Actual No.	1985 Actual Amount	1986 After Sequestering No.	1986 After Sequestering Amount	1986 Revised No.	1986 Revised Amount	FY 1987 Estimate No.	FY 1987 Estimate Amount
Grants:								
Projects:								
Noncompeting......	187	$30,262,000	229	$33,910,000	225	$33,397,000	231	35,492,000
Competing:								
Renewal..........	67	8,721,000	65	10,111,000	64	9,441,000	55	8,000,000
New..............	64	7,663,000	66	6,273,000	65	5,824,000	62	7,931,000
Supplemental.....	(15)	364,000	(8)	400,000	(8)	400,000	(12)	400,000
Subtotal Competing..	131	16,748,000	131	16,784,000	129	15,665,000	117	16,331,000
Subtotal Proj. Grts..	318	47,010,000	360	50,694,000	354	49,067,000	348	51,823,000
(With AIDS Reimbur.)	(321	47,570,000)			(360	50,694,000)	(354	52,778,000)
Centers:								
Noncompeting......	3	2,380,000	3	2,059,000	3	2,059,000	2	803,000
Competing.........	1	232,000	1	455,000	1	455,000	1	274,000
New...............	---	---	---	---	---	---	---	---
Supplemental......	(2)	60,000	---	---	---	---	---	---
Subtotal........	4	2,672,000	4	2,514,000	4	2,514,000	3	1,077,000
Research Scientists:								
Noncompeting......	24	1,306,000	27	1,543,000	27	1,543,000	22	1,279,000
Competing.........	5	286,000	2	120,000	2	120,000	3	173,000
New...............	2	120,000	1	60,000	1	60,000	---	---
Supplemental......	---	---	---	---	---	---	---	---
Subtotal........	31	1,712,000	30	1,723,000	30	1,723,000	25	1,452,000
Small Business ·								
Innovative Research:								
Noncompeting......	2	316,000	---	---	---	---	4	556,000
Competing.........	---	---	4	575,000	4	575,000		150,000
New...............	6	268,000	5	229,000	5	229,000	2	124,000
Supplemental......	---	---	---	---	---	---	---	---
Subtotal........	8	584,000	9	804,000	9	804,000	7	830,000
Small Grants..........	6	118,000	---	---	---	---	4	84,000
Cooperative Agreements	1	26,000	---	---	---	---	---	---
Contracts:								
Renewal..........	19	5,384,000	18	5,336,000	17	5,171,000	17	4,990,000
New..............	1	296,000	5	3,210,000	---	---	3	733,000
Subtotal........	20	5,680,000	23	8,546,000	17	5,171,000	20	5,723,000
Subtotal Other Mechs..	70	10,792,000	66	13,587,000	60	10,212,000	59	9,166,000
(With AIDS Reimbur.)	(—	—)			(64	13,323,000)	(63	13,416,000)
Total Extramural......	388	57,802,000	426	64,281,000	414	59,274,000	407	60,989,000
Intramural Research								
Personnel..........		2,641,000		3,545,000		3,545,000		3,626,000
Other..............		3,317,000		2,991,000		2,417,000		2,790,000
Total..............		5,958,000		6,536,000		5,962,000		6,416,000
Total Research........	388	$63,760,000	426	$70,817,000	414	$65,236,000	407	$67,405,000

Drug Abuse Extramural Research by Mission Objective

	1985 Actual	1986 After Sequestering	1986 Revised	1987 Estimate
Cellular Mechanisms........	$ 7,946,000	$ 8,357,000	$ 8,070,000	$ 8,305,000
Central Nerv. System Mechs.	11,114,000	11,250,000	11,102,000	11,385,000
Behavioral Mechanisms	7,318,000	7,071,000	7,071,000	7,281,000
Chemistry..................	1,879,000	1,928,000	1,928,000	1,986,000
Metabolism & Disposition...	2,078,000	1,928,000	1,928,000	1,986,000
Incidence & Prevalence.....	6,129,000	7,071,000	5,348,000	5,181,000
Risks and Consequences.....	3,391,000	5,785,000	3,966,000	4,252,000
Prevention.................	8,495,000	9,963,000	9,197,000	9,360,000
Treatment..................	6,404,000	7,713,000	7,713,000	7,943,000
Technical Services.........	3,048,000	3,215,000	2,951,000	3,310,000
Total Extramural Research.	$57,802,000	$64,281,000	$59,274,000	$60,989,000
(With AIDS Reimbursement)	($58,362,000)		($64,017,000)	($66,194,000)

Drug Abuse Extramural Research by Drug

	1985 Actual	1986 After Sequestering	1986 Revised	1987 Estimate
Narcotics..................	$14,856,000	$15,750,000	$14,028,000	$14,718,000
Marijuana..................	8,240,000	9,321,000	8,938,000	9,098,000
Cocaine & Stimulants.......	4,694,000	6,428,000	5,662,000	5,819,000
Sedatives..................	2,213,000	2,571,000	2,571,000	2,648,000
Hallucinogens..............	2,542,000	2,571,000	2,571,000	2,648,000
Nicotine...................	4,364,000	3,535,000	3,535,000	3,641,000
Inhalants..................	508,000	1,285,000	1,285,000	1,324,000
Endogenous Substances......	5,021,000	5,785,000	5,785,000	5,957,000
Multiple/Non-Specific......	15,364,000	17,035,000	14,899,000	15,136,000
Total Extramural Research..	$57,802,000	$64,281,000	$59,274,000	$60,989,000
(With AIDS Reimbursement)	($58,362,000)		($62,017,000)	($66,194,000)

Understanding the Molecular and Cellular Actions of Drugs:

At the most basic level, drugs produce their effects by altering the activity of individual cells. Because understanding the nature of these effects and the ways in which they are produced is of such fundamental importance in understanding the causes and consequences of drug abuse, research in this area has always been a high priority at NIDA.

Twelve years ago NIDA grantees led what became a revolution in the neurosciences with the discovery of opiate receptors and endogenous opioid peptides. Work in this area has proceeded at a rapid pace ever since. The importance of this research lies in two areas. First, narcotic abuse remains a serious problem and it is hoped that this research may eventually lead to the development of better treatment techniques. Second, the endogenous opiate system has been found to be one of the major neurotransmitter systems in humans. It has been found to be involved in pain regulation, memory, heart and lung function, and a wide variety of other body functions including immune functioning. Understanding this system is important not only for an understanding of narcotic abuse, but also for a better understanding of how the brain itself works. Current research at NIDA is focused on three major areas: (1) determining the ways in which pharmacologically active opioid peptides are derived from larger peptide molecules, (2) determining structural and pharmacological differences among the opiate receptor types, and (3) determining the intracellular mechanisms involved.

All of the known opioid peptides are derived from three large precursor proteins. For example, beta-endorphin is an active end product in the processing of proopiomelancortin (POMC), which is not itself pharmacologically active. This processing takes place through the action of enzymes which cleave the larger molecule at specific sites and often involves several steps as the original precursor peptide is broken into progressively smaller fragments. Many of these intermediate fragments are pharmacologically active. As we have learned more about this system it has become clear that a systematic study of both the opioid peptides and the enzymes involved in their processing is needed to understand fully the workings of endogenous opiate system.

In the last year, NIDA grantees at Johns Hopkins University discovered an important enzyme, peptidyl-glycine alpha-amidating monoxygenase, or PAM, which fully activates many peptides. PAM acts on small peptides which end with a carboxyl group by altering the carboxyl group and adding an amide group. The importance of this enzyme lies in the fact that over half of all known pharmacologically active peptides have an alpha-amidated carboxyl terminus, and the alpha-amidated carboxyl terminus is necessary for full pharmacological activity. The distribution of PAM is also being studied. In rats, the highest concentrations have been found in the anterior and neurointermediate lobes of the pituitary. Lower concentrations have been found in the hypothalamus, submaxillary glands, and in the rest of the brain. Further work on this and other enzymes will be a high priority in FY 1987.

A second area of research involves investigations of the different types of opiate receptors. Three major types of opiate receptors have been identified (mu, kappa, and delta), but major questions remain concerning the nature and functional significance of their differences. Progress in this area has been made. For example, the mu receptor has been found to be involved in analgesia within the central nervous system, delta receptors act locally in the intestine to control secretion, and both mu and delta receptors are involved in bowel function. Research has been hindered, however, by the difficulties involved in clearly defining the specific characteristics of each receptor type.

Several groups of NIDA grantees have been working to isolate and characterize receptors and, although many partially purified receptor preparations have been developed, it is only in the last year that an active and nearly 80 percent purified receptor has been identified. Other NIDA investigators have taken a different approach to the study of opiate receptor sub-types; they have prepared monoclonal antibodies for specific peptides. The use of these antibodies makes it possible to detect which peptides bind to specific receptor types. The use of this technique should make future research to determine the functional significance of the different opiate receptor types more productive.

The third area of research concerns how the signals transmitted through opiate receptors are processed within the cell. Recent studies on isolated cell cultures indicate that only one type of receptor is located on any one neuron and that different receptors appear to regulate different cell functions. For example, mu and delta receptors regulate potassium ion flow through calcium-dependent potassium channels in the cell wall. Kappa receptors appear to act on voltage-dependent calcium channels in the cell wall. Much current research is focused on adenyl cyclase, a "second messenger." When a peptide binds to an opiate receptor on the cell wall, the signal is conveyed within the cell by adenyl cyclase. Most neurotransmitters exert their action by increasing adenyl cyclase action. Opiate peptides appear to have the opposite action, inhibiting adenyl cyclase action within the cell.

While a major part of NIDA's research on the cellular mechanisms of drug abuse has focused on opiates, an increasing amount of effort has gone into investigations of other drugs. To a large extent, this is because of the success of the work on opiate receptors, which has become a model for research on other drugs. Current research is focusing on marijuana and cocaine. Recently studies have found evidence of binding sites for components of marijuana in the brain. Future research will explore these findings and attempt to clarify the mechanisms involved. Receptors for cocaine have also been identified in the brain, and work is now planned to map the distribution of these receptors throughout the brain. If these findings are confirmed, it will greatly increase our understanding of how these drugs affect the central nervous system.

Understanding the Actions of Drugs on the Central Nervous System:

To understand fully how drugs affect the brain, one must understand not only how they affect individual cells, but how they affect systems or circuits of cells within the central nervous system. While research in this area has been conducted for some time, it was not until relatively recently that a combination of theoretical and technological advances opened the way to more rapid progress.

One of the most exciting areas of this research involves investigations of brain reward systems. While it has long been suspected that there are specific circuits within the central nervous system that are involved in reward, it has only been recently that technological advances in drug abuse research have made it possible to conduct meaningful research on this hypothesis. The major technological advance has been the development of ways of delivering very precise microdoses of drugs directly into specific areas of the brains of living animals. With this technique, researchers can determine the effect of the drug on specific structures of the brain.

One of the first findings to emerge from this research concerned narcotics. Narcotics produce a number of effects, including euphoria, analgesia, the development of tolerance and dependence, and lowered respiration rates. NIDA researchers were able to show that two of these effects, euphoria and tolerance, were due to the action of the drug at anatomically and functionally distinct sites in the brain. This finding has major theoretical and practical implications.

First, the fact that the tolerance and dependence produced by narcotics is associated with its action at specific sites in the brain suggests that it may be possible to develop more effective analgesics for use in the treatment of pain which avoid the undesirable side-effects of drugs currently used. As we learn more about the pain regulation system and the role of specific narcotic receptor types in it, it may be possible to develop analgesics with chemical structures specifically tailored to act on the pain regulation system and with little or no effect on those systems involved in the development of tolerance and dependence.

Second, it demonstrates that it is a mistake to associate "drug addiction" with the development of tolerance to analgesia or with classical opioid withdrawal symptoms. For while the avoidance of withdrawal can become a motivating force for drug use, it may not be the motivating force for the use of all drugs. For example, nonaddicted rats will self-administer narcotics when the drug is inserted directly into certain areas of the brain associated with its rewarding features, and they will do so compulsively. These rats do not develop tolerance and do not show classical withdrawal symptoms when the drug is stopped. They will not self-administer narcotics when they are inserted into areas of the brain associated with tolerance to analgesia and the more observable withdrawal signs unless these areas have previously been "primed" with narcotics. This implies that it is a mistake to believe that because certain drugs, such as cocaine, do not produce withdrawal symptoms of the opiate type they are not "addicting."

Studies of the reward circuitry of the brain performed over the last few years provide further evidence for these new insights into "addiction." It has been found in one series of experiments that cocaine and narcotics produce their rewarding effects by producing the same biochemical response in the ventral tegmental area (VTA) of the brain. The VTA is a nucleus of dopaminergic cell bodies with nerve terminals extending into the cortex and limbic regions of the brain. Both narcotics and cocaine, although through different pathways, increase the release of dopamine in the VTA. Studies performed in the last year suggest that both cerebral laterality (the relative dominance of one side of the brain over the other exemplified by right or left handedness) and sex may affect the reinforcing properties of drugs on this system. Cocaine appears to lessen cerebral dominance in female rats while increasing it in male rats. It appears that this difference may be due to differences in receptor density and reuptake sites in male and female rats. Further work in this area will be a high priority in the future.

Understanding the Behavioral Effects of Drugs:

NIDA's research on the behavioral effects of drugs can be divided into two broad categories: basic research designed to determine the precise effects of drugs on the central nervous system through an analysis of the effects of drugs on behavior, and applied research to determine the effects of drugs on performance. These two areas are obviously closely related, yet there are important differences between them, both in the objective of the research and the methods used.

One of the crucial steps in understanding how drugs affect the central nervous system is to determine precisely what their effects on behavior are. However, because behavior is the result of activity throughout the central nervous system, which is affected by outside environmental stimuli as well as internal events, the effects of drugs on the central nervous system can often only be determined by examining changes in behavior in response to different pharmacological and environmental variables. In recent years, improved laboratory techniques have made it possible to obtain precise, quantifiable measures of changes in behavior. These methodological and technological advances are now being applied to studies involving both animals and humans.

For example, studies of the behavioral effects of administering drugs at various doses, at different intervals, and under different environmental conditions provide valuable information about the pharmacological properties of particular drugs and how they effect the central nervous system. While much of this research is of a basic nature, it has often had important practical consequences. For example, studies of the effects of environmental factors on narcotic use and cigarette smoking has helped to explain why relapse rates for users of these drugs are so high and has led to the development of new and more effective treatment approaches. The ability to measure more precisely the effects of drugs on behavior has enabled researchers to detect effects of drug use at much longer intervals after use than ever before. This research has detected changes in behavior, which would previously have gone undetected, that have important public policy implications.

NIDA's applied research on the effects of drugs on performance is directed at determining the risk posed by drug use on the ability of people to safely and effectively carry out complex activities involved in work and everyday life. For example, two NIDA grantees have studied the effects of marijuana smoking on the behavioral and cognitive performance of pilots. Using a flight simulator, the performance of pilots was studied after the pilots smoked a single marijuana cigarette. They found that detrimental effects lasted for at least 4 hours, and that overall ability was affected for up to 24 hours. Similar studies have also been made of the effects of various drugs on automobile driving skills.

Another aspect of this research program involves the development of reliable tests for drug intoxication. As the public has become more concerned about safety and less tolerant of drug-related accidents, there has been an increasing demand for the development of reliable means of determining drug intoxication. At present, there are no satisfactory tests for drug intoxication. The ability to predict the behavioral consequences of taking a drug are limited to generalizations such as that high doses generally have a greater effect than low doses, and that well-learned skills are less affected than novel tasks. Although the presence of drugs can be detected in various body fluids, this information cannot be correlated to precise levels of performance impairment. Research in this area is now a priority at NIDA. Recent studies suggest that performance impairment may be a function of the rate of change of drug concentration in the blood for some drugs or that the concentration of active metabolites may be more directly correlated with behavioral change.

In a related area, research is also being supported to develop better ways of detecting levels of drugs in body fluids. The technology for detecting alcohol in biological samples has been clearly determined and the procedures are well established. It is even possible to accurately estimate blood levels of alcohol from the content of passively expired air. Currently, no such tests are available for marijuana, cocaine, stimulants, and most other drugs. Taking blood samples is not a useful method for routine drug screening and research to date indicates that behavioral impairment does not correlate well with plasma concentrations of most drugs. NIDA has, therefore, initiated research to explore alternative, non-intrusive ways of assessing drug-impaired functioning. It now seems possible that current technologies could be used to develop a single or small battery of test procedures to assess acute and chronic drug effects on psychomotor and cognitive performance.

Understanding the Chemical Composition and Structure of Drugs:

One of the basic tasks of drug abuse research is to understand the chemical composition and structure of abused drugs and endogenous substances. NIDA's efforts in this area include not only the analysis of the chemical structure of abused drugs, but also the synthesis of new substances for research and treatment. Recent technological and theoretical advances in chemistry have made it possible to correlate the physiochemical properties of substances, e.g., lipid solubility, molecular weight, and atomic structure, with their biological effects. This knowledge can be used in what is essentially molecular engineering to synthesize new substances with very specific properties. For example, a NIDA grantee is using crystallographic techniques to investigate the three-dimensional stereochemical features of certain endogenous opioids. The goal of this research is to determine the molecular features of compounds which bind to mu and delta opiate receptors. Another NIDA grantee is investigating the mechanisms involved in the neurotoxicity of synthetic drugs such as MPTP and PCA. It appears that the neurotoxicity of these substances may be due to metabolities which bind to tissues. Such binding is species specific, which is in agreement with the observation that the neurotoxicity of these substances is also species specific. These techniques are also being used in studies of marijuana and hallucinogens. Two NIDA grantees are investigating the quantum mechanical properties of several hallucinogens. The purpose of this study is to determine the chemical and physical properties of hallucinogens and the receptors to which they bind. Another grantee is searching for molecules which act as receptors mediating the effects of THC, the primary active component of marijuana. This project involves the use of monoclonal antibodies which can be used to detect the sites at which THC acts in the central nervous system. If these and similar research efforts are successful, they will result in a major improvement in our understanding of how hallucinogens and marijuana affect the brain.

Understanding the Metabolism and Disposition of Drugs:

Information on the metabolism and disposition of drugs is essential for understanding how drugs affect the body and for the development of effective treatment techniques. Research in this area involves the identification of the metabolites of drugs, elucidation of metabolic pathways, and the time course of action of drugs as they pass through the body. Currently research on a number of drugs is receiving special priority.

Recent work on cocaine has resulted in the identification of a number of its metabolites. Several of these metabolites are present in fairly large concentrations and are believed to be able to cross the blood-brain barrier. One of the major metabolites, benzoylecgonie, has been found to have little pharmacologic effects itself, but it appears to inhibit the elimination of cocaine from the body.

In the last several years, NIDA's research on cocaine has increased, but one area where relatively little work has been done is on coca paste. While coca paste has not been extensively available in the United States, it is the primary form in which the drug is used in Latin America. Because of the concern that coca paste may become widely available in the United States, NIDA is initiating research on its potency, toxic adulterants, and the particular problems which might be associated with smoking this form of cocaine. Preliminary evidence from Columbia indicates that the heavy use of coca paste results in mental and physical pathology which may be due more to the properties of the paste and the way in which it is taken than to the effects of cocaine itself.

Research on marijuana suggests that cannabinoids are sequestered in body tissues from which they may be released for some time after the use of marijuana has stopped. Studies by a NIDA grantee of chronic marijuana users indicate that plasma levels of THC can be followed for more than eight days after the use of marijuana has stopped. THC is eliminated from the body primarily through metabolism. While many of the metabolites have been identified, it is believed that there are a large number as yet unknown. NIDA grantees are currently working to identify these metabolites. As urinalysis is now widely used for screening of drug use, this information will be important for the confirmation and validation of urine-based tests for marijuaua use.

There has also been speculation that PCP is stored in body tissues. Because PCP is commonly abused by smoking, studies are also being initiated to identify PCP pyrolysis products. Recently a NIDA grantee has begun studying PCP in animals using immunotoxicokinetic techniques. He is investigating the use of PCP specific antibodies as a way of eliminating PCP from the body. Preliminary studies in animals suggest this may be possible. This investigation could lead to the development of an effective treatment for PCP in humans. In fact, the use of monoclonal antibodies as a way of treating PCP may open the way for the development of totally new and much more effective clinical treatment modalities for a wide range of drug overdose effects.

Monitoring the Incidence and Prevalence of Drug Abuse:

One of the major problems involved in Federal and State efforts to combat drug abuse is the wide fluctuation that occurs in both the numbers of people using drugs and the ways in which they use them. Our current experience with cocaine is an example. The number of people admitted to hospital emergency rooms following cocaine use increased by 300 percent between 1980 and 1985. Changes of this magnitude are rarely found in the public health areas, but are quite common in the drug abuse field.

Because of the importance of identifying changes in the number of people using drugs and patterns of use as quickly as possible, NIDA has devoted considerable effort to its epidemiological programs. Currently, three major data collection systems are in place. The Drug Abuse Warning Network (DAWN) collects information on an ongoing basis on drug-related episodes from a selected group of hospital emergency rooms and medical examiners' offices. The High School Senior Survey, which is conducted annually, collects information on patterns of drug use and attitudes toward drug use from high school students. This effort is considered exceptionally important because patterns of drug use are frequently established during the high school years. Finally, the Household Survey, conducted every two years, collects information on patterns of drug use and attitudes toward drug use from selected households throughout the United States.

While these data collection systems represent tremendous progress compared to what was available twelve years ago, several serious problems remain in our ability to collect drug abuse information. We have not yet been able to find satisfactory ways of collecting information from important groups in the population, such as high-school dropouts, college students, and the homeless. Because drug use is thought to be more common in these groups than in the general population, we are currently devoting considerable effort to find ways to improve our ability to study these populations.

Another problem concerns the costs of our current efforts. Ongoing systems such as DAWN and major surveys such as the High School Senior Survey and the Household Survey are expensive to conduct. Because of this, we are limited in both the kinds of information we can collect and the frequency with which it can be collected. As a result, a high priority has been placed on finding alternative data collection techniques that, while less expensive than current efforts, would allow us to expand the range of information we can collect. Progress has been made in this effort. This year questions were added to an 1985 Gallup Poll which provided information about alcohol, marijuana, and cocaine use. This effort demonstrated that valuable drug abuse prevalence information could be obtained in this manner at considerably less expense than would be involved using traditional survey techniques. In a related effort, a study is now underway to test the feasibility of using telephone surveys to measure drug use, attitudes, and other drug abuse related issues. If reliable information can be obtained this way, it would provide a relatively inexpensive and very rapid method for obtaining information on drug abuse trends.

Understanding the Risks and Adverse Consequences of Drug Use:

Research to determine the adverse health and behavioral consequences of drug use has always been a major part of NIDA's research portfolio. It serves two major functions. First, findings about the risks posed by the addictive disorders have major implications both for public policy and the direction of our research program. Second, the dissemination of scientifically accurate assessments of the risks posed by drug abuse have played an important role in the development and success of our prevention programs.

Over the twelve years of NIDA's existence, the consequences of virtually every aspect of drug abuse have been investigated. In recent years the emphasis of the program has been altered in response to changes in drug use patterns and the emergence of new drug problems. For example, because the incidence of chronic marijuana use has become so common, many of our studies are now less concerned with immediate effects than long-term consequences. The smoke of marijuana contains many of the same respiratory irritants found in tobacco smoke, in addition to approximately 60 cannabinoid compounds. As a result, increasing emphasis has been placed on clarifying the potential long-term pulmonary consequences of marijuana use. Similarly, in view of the increasing numbers of women of child bearing age who use marijuana, research has been initiated to determine the effects of maternal marijuana use on reproductive function and on fetal development.

Similar lines of research have been initiated with cocaine. Cocaine and other stimulants are known to effect the cardiovascular system, but the long term consequences of their use are not clear. Some of the questions of particular concern revolve around whether the cardiovascular effects of chronic or acute cocaine use are complicated during stress or exercise. There is also concern about the effects of cocaine on the contractility of cerebral blood vessels. Some researchers believe that cocaine and amphetamine may be involved in the development of cerebral arterial spasm, a major cause of morbidity and mortality.

Another recent problem requiring attention concerns the so-called "designer drugs," which are synthetic versions of narcotic or stimulant compounds. These substances pose two major dangers. First, some have biochemical properties that make them more dangerous than the drugs from which they were derived. Second, they are frequently contaminated with dangerous by-products. In 1985, NIDA and the Centers for Disease Control collaborated in a field study to locate victims of methylphenyltetrahydropyridine (MPTP). MPTP is a by-product in the synthesis of the synthetic narcotic 1-methyl-4-phenyl-4-proprionxypiperidine (MPPP). It has been found to cause Parkinsonism when injected intravenously. The profound danger of this compound makes the identification of cases and the development of prevention programs especially important. Another synthetic drug, 3,4-methylenedioxyamphetamine (MDA), which is a synthetic amphetamine, has been found to be a potent neurotoxin which destroys serotonin neurons in the brain. The mechanisms through which this happens is under investigation in the hope of developing ways of treating people who have used it.

A fourth area in which research has recently been expanded concerns the effects of drugs on the immune system. Recent work in this area with animals has show that marijuana can alter normal immune function and that certain viral infections can be exacerbated by marijuana use. It has also been determined that the immune system is subject to modulation by the central nervous system, and that endorphins are involved in this process. In fact, opiate receptors have been found on some immune system cells. While this research is of a preliminary nature, it strongly suggests that drug use may have significant effects on normal immune system functioning. Research in this area has been given a high priority for FY 1987.

Developing Effective Drug Abuse Prevention Programs:

NIDA's prevention program consists of three major components: abuse liability studies designed to identify new substances with a high potential for abuse and restrict their availability, etiological research to determine the factors which either increase or decrease an individual's likelihood of abusing drugs, and prevention program evaluation to develop more effective drug abuse prevention programs.

While a major part of NIDA's abuse liability program is conducted intramurally at the Addiction Research Center, a significant portion is also conducted extramurally in four major projects. Research is performed on new substances to determine their reinforcing properties and to identify any potential toxicity. The information obtained from this research is used by the Drug Enforcement Administration in the scheduling of drugs. As a result of this effort, the availability of drugs with a high likelihood of being abused, or with exceptionally dangerous consequences, are restricted. This has proven to been an especially effective form of prevention.

NIDA's etiological research is intended to clarify the risk factors associated with drug abuse and is intended to clarify both those factors which increase and those which decrease the risk of compulsive drug use. The major purpose of this program is to guide the development of preventive interventions and to identify populations at high risk for drug abuse.

The most significant finding from etiological research concerns the importance of considering drug use in relation to normal human development. Because risk taking during adolescence is to some extent normal and necessary for full personality development, one challenge for drug abuse prevention is to channel normal risk taking tendencies into more constructive outlets. Drug use, for most adolescents, tends to be associated with peer influence, and does not necessarily derive directly from psychopathology or family influences. However, family influences can indirectly affect adolescent drug use. For example, adolescents who identify with one or both parents tend to select peers who reflect values similar to those of the parents. For a small proportion of the population drug abuse appears imbedded in family conflict, school failure, and antisocial behavior. This small group, however, accounts for six to eight times its proportionate share of compulsive and problem drug users.

According to studies of elementary school-aged children, children's attitudes toward the use of medicines and abuseable substances appear to be linked. These attitudes and beliefs appear to stabilize at approximately 10 years of age. At about this time, parental influences are also being modified by socialization of the child by media, peers, and the parents of the child's peers, leading to closer identification between the child and the environment outside the family. Developmentally, children of this age have not yet attained formal operational thought based on logic and abstract reasoning, which is usually attained in early adolescence. Prevention messages and programs thus need to respect the cognitive capacities of children, the autonomy they have over their own health practices, and the influences operating in their home, school, and community. A current study is testing the effects of message style and format in producing more effective drug abuse prevention literature.

NIDA's etiological research program will continue to emphasize the exploration of genetic, family, and peer influences on drug use behaviors. Environmental influences, which have received relatively little attention to date, will also receive attention. These factors would include both community influences and cultural influences at the broader, societal level, particularly influences from the entertainment industry and other mass media. Increased attention will be given to differentiating various types of drug use phenomena and their distinct etiological roots, such as a current study examining the use of smokeless tobacco and the role it plays among adolescents in the development of cigarette smoking. While much has been learned about the etiology of drug use, the implications for preventive interventions are often difficult to put into practice. In-depth studies using multiple assessment techniques are needed to clarify further the action and interactions of relevant risk factors in order to discern intervention implications. Another priority is research on ethnic minorities and other groups whose unique cultural traditions and life experiences may contribute to different patterns of risk. Children of substance abusing parents are at particularly high risk and require special attention.

NIDA's prevention intervention research program is focused largely on school-based, family, and community prevention approaches. Several programs have been tested and found to be effective. One of these strategies, the "Just Say No" approach, has been widely implemented. Further research priorities include further confirmation of the long-term effectiveness of these programs. Research is also needed to differentiate the students with whom these programs are and are not effective. Most research to date has been conducted on largely white, middle class students. The extent to which these approaches may be generalized to low income and ethnic minority groups is not known. Research to address this question is currently in progress. One such study is evaluating the reduction in drug abuse among American Indian youth by training indigenous counselors to provide effective treatment and prevention services. Another is investigating the effectiveness of various prevention techniques among Hispanic and non-white students in Los Angles. To date research on these approaches has been conducted under controlled conditions with research staff delivering or carefully overseeing the delivery of the intervention program. While this was necessary to assess the programs' effectiveness, research is now needed to assess the efficacy of these programs implemented under less controlled conditions and with the resources available to most school systems. Research is also needed to address issues related to dissemination such as the acceptability of instructional methods to classroom teachers and administrators, possible roles for peer leaders, packaging of programs to promote their use, and teacher training modules.

While the programs described above appear to be effective for many youth, they may not be effective for certain groups at high risk of using drugs. Many of these youths cannot be effectively reached through school programs because they have dropped out or are alienated from the school environment. Entirely different approaches must be developed for this population. NIDA has recently initiated research on a variety of ways of reaching these youth. One is testing the effectiveness of brief family therapy in the treatment of adolescent drug abusers and in the prevention of drug abuse among younger family members. Another involves family life skills training approaches, which seek to develop effective parenting skills and family interaction patterns. A third is focused on the role of parent action groups in the prevention of drug abuse.

NIDA has also initiated a community prevention research program to test the effectiveness of community wide prevention programs. Based on the progress that has been made in drug abuse prevention, and in research on community prevention in other health fields such as cardiovascular disease prevention, this program will encourage well controlled and scientifically rigorous community prevention research of multiple prevention strategies focused on the individual, the family, schools, media, health care providers, and community organizations.

Development of More Effective Drug Abuse Treatment Programs:

Over the last twelve years significant progress has been made in our understanding of how to treat opiate abuse among the traditional opiate-abusing populations. During this time, however, other drug problems have emerged. Experienced opiate addicts have begun to use different chemicals such as PCP, cocaine, and synthetic drugs. Adolescents and young adults have been increasing their use of mind-altering substances, especially stimulants such as cocaine. Many elderly patients have been found to misuse or abuse various prescription and over-the-counter drugs. As these problems have emerged, it became clear that techniques developed to treat young adult narcotic addicts were not always appropriate or sufficient to address the needs of the many people exposed to an ever-increasing range of substances.

Accordingly, over the past year there has been a shift in the emphasis of NIDA's treatment research program. Currently, less emphasis in being placed on the evaluation of opiate-related treatment, and significantly more emphasis is being placed on research on techniques appropriate for the treatment of non-opiate drug users. New research includes matching specific treament modalities with patient characteristics and drug use patterns and identifying prescription drugs, such as antidepressants, which can be effectively used as adjuncts to psychotherapeutic and behavioral management approaches for treating drug abuse. Investigators have learned a great deal from previous research and are applying these findings to the development of new treatment methodologies. For example, cocaine treatment strategies are being employed at the present time which draw on our knowledge of the neurochemical and behavioral effects of cocaine. Past clinical research on the factors which reinforce drug use are being applied in the development of treatment techniques for cocaine abusing young adults. Research is being encouraged on factors that contribute to relapse to drug use following treatment and on developing procedures that can be applied during treatment to prevent or reduce the likelihood of future relapse.

Important advances in the development of therapeutic drugs are permitting us to evaluate the use of a range of agents in the treatment of all forms of drug abuse. Treatment of cocaine users with antidepressants and other pharmacological adjuncts is likely to contribute to treatment success. NIDA has supported studies which contributed to the evaluation of nicotine gum as an adjunct in the treatment of tobacco use. We are also supporting studies to determine other effective ways of treating tobacco use. One of the spin-offs of this research is that we also learn more about other types of drug abuse problems and how they may be treated.

While significant progress has been made, there remain major gaps in our ability to effectively treat drug abusers. For example, while much is known about the treatment of narcotic users, and progress is being made in the treatment of cocaine abuse, very little is known about how to effectively treat PCP and marijuana users. Research on treatment programs for these drugs, and for adolescents, will be priorities in FY 1987.

Providing Technological Services in Support of Drug Abuse Research:

While major breakthroughs in our understanding of the biological and behavioral processes in the health field are often widely publicized, the major and minor technological breakthroughs that made these discoveries possible are usually ignored. As biomedical research has become more sophisticated, this lack of attention has begun to create serious problems. For example, fifteen years ago most drug abuse research was conducted with purified samples of abused drugs. Obtaining these drugs was difficult only because of the illicit nature. Now, however, because of major technological advances such as PET and NMR scanning, the use of monoclonal antibodies, immunoassays, and high performance liquid chromatography, a whole new set of substances have become crucial to the continued progress of drug abuse research. NIDA now supplies drug abuse researchers with radio-labeled drugs, endogenous substances, receptor agonists and antagonists, and structurally altered versions of abused drugs. Many of these substances have few, if any, commercial uses and are either not commercially available or available only at great expense. As a result, NIDA produces them through contracts and provides them to drug abuse researchers.

NIDA's technological services program consists of three main parts: the drug supply program, the analytical services program, and research grants to develop new techniques for drug abuse research. Research materials are produced through several drug supply contracts. These contracts are used to provide drug abuse researchers with a wide variety of research materials involved in drug abuse research, ranging from standardized samples of marijuana to radio-labeled drugs. Recently, this program has been used to develop pure samples of synthetic drugs which were provided to researchers for abuse liability and toxicity testing. The analytical services program provides analytical services to researchers in the drug abuse field. For example. radioimmunoassay (RIA) kits are provided to investigators studying marijuana, opiates, and the endogenous opiate system. The grants program is used primarily to develop new research techniques. Current work includes research to develop more effective ways of detecting marijuana and other illicit drugs in body fluids, attempts to improve fluorescent immunoassays for drug abuse research, and to expand the use of monoclonal antibodies in drug abuse research. Work in this area is vital to the continued success of NIDA's research program.

Acquired Immunodeficiency Syndrome (AIDS)

NIDA is concerned with AIDS because intravenous (IV) drug users constitute a significant proportion of individuals with AIDS. Nationwide, approximately 63 percent of the cases of AIDS are among non-IV using homosexual men, 8.5 percent are among homosexual IV drug users, and approximately 17 percent are among heterosexual intravenous drug users. AIDS is transmitted among intravenous drug users primarily when needles and other paraphernalia used to inject drugs are shared.

There is considerable variation in the incidence and prevalence of AIDS from one geographical region to another. Five states--New York, California, Florida, New Jersey, and Texas--have three-quarters of all AIDS cases. In the New York area, 38 percent of reported AIDS cases have a history of IV drug use, while in California, 17 percent of AIDS cases have such a history. Pediatric cases represent less than 1 1/2 percent of the total AIDS cases; however, 52 percent of these children have an IV drug-using parent.

Approximately 44 percent of those entering detoxification programs in New Jersey tested positive for antibodies to the Human T-Cell Lymphotropic virus (HTLV-III), the virus that causes AIDS, and one-third of those in methadone maintenance programs tested positive. About 95 percent of the drug users in this study reported sharing their needles. In other areas of the country, such as New Orleans where intravenous drug use rates are high but large-scale needle sharing is not a common practice, lower numbers of AIDS cases occur among IV drug users.

NIDA has been actively participating on the PHS Executive Task Force on AIDS and has membership on the various subcommittees of the task force. We have participated in numerous congressional hearings on the topic and have responded to a ground-swell of requests for technical assistance. To assure that a coordinated and meaningful program is initiated, an AIDS Task Force has been established in the Office of the NIDA Director. It is charged with coordinating activities, monitoring the progress of the overall effort and preparing consistent and coherent reports on NIDA's research and prevention initiative. In addition, a new branch is being established in the Division of Clinical Research to launch an aggressive clinical research program into the area. A grant announcement has recently been issued to stimulate more research in this area.

A major goal of this research program will be to clarify the epidemiology and natural history of HTLV-III infection among IV drug users. While it now appears clear that the spread of the HTLV-III virus among IV drug users is primarily due to the sharing of needles, there are a number of questions about the extent to which the virus has been spread and the role of drug use in the development of the overt disease once an individual has been exposed to the virus. It has been noted that AIDS victims who are IV drug users experience different diseases and tend to die in a shorter period than AIDS victims without a history of IV drug use. This suggests that, while the initial exposure to the virus in drug users may be due to needle sharing, the subsequent development of AIDS and the course of the disease may be influenced by drug use. Over the last several years NIDA has developed evidence that drug use can impair immune functioning. Further research in this area will be conducted to determine if drug use may increase the risk of developing AIDS and altering the course of the disease once it is contracted.

In accordance with Administration intent to focus all support for AIDS in the Office of the Assistant Secretary for Health, the funds earmarked for NIDA activities in this area have been transferred to OASH in 1987.

Drug Abuse Intramural Research by Mission Objective

	1985 Actual	1986 After Sequestering	1986 Revised	1987 Estimate
Cellular Mechanisms.......	$ 133,000	$ 618,000	$ 498,000	$ 556,000
Central Nerv. System Mech..	2,629,000	2,474,000	2,474,000	2,551,000
Behavioral Mechanisms......	1,480,000	1,435,000	1,435,000	1,540,000
Chemistry..................	415,000	196,000	196,000	210,000
Metabolism & Disposition...	484,000	331,000	331,000	361,000
Incidence & Prevalence.....	—	72,000	—	—
Risks and Consequences.....	468,000	819,000	437,000	482,000
Prevention.................	137,000	131,000	131,000	180,000
Treatment..................	182,000	427,000	427,000	501,000
Technical Services.........	30,000	33,000	33,000	35,000
Total Intramural Research.	$5,958,000	$ 6,536,000	$ 5,962,000	$ 6,416,000
(With AIDS Reimbursement)	(—)		($ 6,536,000)	($ 7,016,000)

Drug Abuse Intramural Research by Drug

	1985 Actual	1986 After Sequestering	1986 Revised	1987 Estimate
Narcotics..................	$ 2,686,000	$ 1,651,000	$ 1,651,000	$ 1,575,000
Marijuana..................	570,000	915,000	724,000	982,000
Cocaine & Stimulants.......	1,600,000	1,587,000	1,491,000	1,605,000
Sedatives..................	555,000	523,000	523,000	561,000
Hallucinogens..............	169,000	196,000	196,000	210,000
Nicotine...................	265,000	915,000	915,000	982,000
Inhalants..................	—	96,000	—	—
Endogenous Substances......	—	457,000	337,000	371,000
Multiple/Non-Specific......	113,000	196,000	125,000	130,000
Total Intramural Research..	$ 5,958,000	$ 6,536,000	$ 5,962,000	$ 6,416,000
(With AIDS Reimbursement)	(—)		($ 6,536,000)	($ 7,016,000)

The Addiction Research Center (ARC) in Baltimore, Maryland, conducts a broad spectrum of research on drug abuse ranging from basic investigations of the role of opiate receptors and endogenous peptides in the central nervous system to the development of more effective treatment methodologies for drug users. With the completion of the move into new facilities in Baltimore, it has become possible for the ARC to envigorate many of its former programs, especially in the areas of the neurosciences and treatment, two areas where the ARC has a long history of achievement.

The ARC has been able to reestablish and expand its neurosciences program and has recruited a world famous neuroscientist, Dr. Michael Kuher, who was Professor of Neurosciences at Johns Hopkins University prior to assuming the role of Branch Chief for Neurosciences at the ARC. One of the important advantages of the ARC's neuroscience program is its close collaboration with the ARC's preclinical and clinical laboratories. This collaboration allows findings initially developed in work at the receptor level to be evaluated with sophisticated animal models of behavior and then, when appropriate, investigated in human volunteers in controlled, clinical tests. As a result, findings with potential clinical significance in the treatment of drug abuse or prevention of drug toxicity can be quickly evaluated in human subjects.

Over the past few years, researchers at the ARC have made significant contributions to the understanding of tobacco dependence. Much of the current acceptance of the role of nicotine as a psychoactive reinforcing drug is based on work at the ARC showing that animals and humans will self-administer nicotine intravenously. More recently, ARC researchers have provided major research support for the Surgeon General's initiatives on smokeless tobacco and have conducted studies on the effects of nicotine chewing gum.

Currently, a high priority has been placed on investigations of cocaine. While two, and possibly more, binding sites for cocaine have been found in the brain, it is not yet clear which of these are involved in the production of cocaine's euphoric effects. The clarification of this question could lead to the development of drugs which could block the action of cocaine. Studies are also under way to determine the distribution of cocaine binding sites in the brain and to determine their functional significance. Simultaneously, clinical researchers are examining the effects of cocaine infusions on human volunteers. This work has recently shown that while tolerance develops to the "rush," there is far less tolerance to the cardiovascular effects of cocaine. Subjects who try to get repeated experiences of the "rush" may experience fatal cardiovascular consequences.

Research has also been expanded on two synthetic, or "designer" drugs, MDMA and MDA. Both of these drugs are derivatives of amphetamine, and have hallucinogenic as well as stimulant properties. Our initial studies indicate, however, that both MDMA and MDA exert potent effects on brain recognition sites distinct from those associated with the actions of common stimulants and hallucinogens. In addition, MDA has been found to be a potent neurotoxin which destroys serotonin neurons in the rat brain. Neurochemical techniques are being applied to elucidate the specific mechanisms through which these substances produce their effects. Studies are being initiated on both the acute and chronic effects of MDA and MDMA and will provide information about the short and long term biochemical changes and neurotoxic effects associated with their use.

The ARC was the first laboratory to demonstrate that the opioid drug buprenorphine has unique properties: it causes very little in the way of withdrawal when stopped abruptly and has a very high margin of safety. Heroin addicts given buprenorphine show dramatic decreases in opioid-taking behavior. Work continues at the ARC to define the dosage and drug forms that would permit buprenorphine to be used as an effective and suitable alternative to methadone.

The ARC has been attempting to give greater emphasis to problems of prevention by initiating work with high risk adolescents - young people who have already gotten into difficulty because of aggressive or antisocial behavior but who have not yet become serious drug abusers. Research sponsored by NIDA and ADAMHA has shown that young people who are delinquent (especially the more serious offenders) are 6 to 8 times more likely to develop serious drug problems. Indeed, the 4.5 percent of the population of young people falling into the category of serious offenders account for about 38 percent of the serious problem drug abuse population. The ARC is attempting to launch a multidisciplinary study of such young people that will focus on a possible genetic or biological bases for their hyperaggressivity and mood impairments.

Working relationships have been established with the Baltimore City Public Schools and the Foundation for Youth Impact, a school for students who have been suspended or expelled. Discussions are also underway with the State of Maryland, Department of Health and Mental Hygiene, Division of Juvenile Services to secure their cooperation in this study. The study will compare adolescents expelled from public schools for disciplinary reasons, such as fighting and drug or weapons violations, with students from similar backgrounds who appear resistant to such behavioral problems. This pilot study will serve as a basis for long term work into the neurophysiological, psychological, and social bases of conduct disorder in an effort to develop appropriate interventions and treatments. The first 25 adolescents have been selected for the study.

Studies of young adults have also begun on those young adults who have traditionally been the volunteer subjects in the ARC's studies of abuse potential. A screening battery of psychodiagnostic tests have been implemented to assess the psychiatric and emotional state of volunteer participants before they become actively engaged in ARC studies. Data obtained from these tests will be compared with populations who have not abused drugs to determine whether there are any significant biological, psychological or sociological markers for substance abuse. Preliminary results from research conducted on the first of these subjects indicates that there are biological differences. Electrophysiological measures of brain function have previously been shown to be correlated with aggression and psychopathology. Electrophysiological measurements of the brain function of the initial 51 subjects in the ARC study indicate that subjects with more severe psychiatric or personality disturbances deviate significantly from the norm. Additional tests will be used to determine whether these deviancies are the result of past drug use and whether behavioral observations conducted in the laboratory can be correlated with them.

While a high priority has been placed on the reestablishment of the ARC's treatment and neurosciences research programs, other ongoing programs have not been neglected. One of the oldest and most important of the ARC's efforts is the abuse liability program. This program tests new substances to determine the likelihood with which they will be abused and whether they have any toxic effects. This information is provided to the Department of Justice which uses it to place controls on the availability of the substance. As a result of this process, the availability of many drugs with high abuse potential has been restricted, and their abuse reduced. The ARC has been a pioneer in the development of methodologies for conducting abuse liability studies. And while, in recent years, a number of other laboratories have begun to conduct abuse liability studies in animals, the ARC remains the leading laboratory for such studies in humans.

Rationale for the Budget Request:

The FY 1987 budget request is $454,000 more than the current estimate for FY 1986 and provides funds for all mandatory increases and decreases.

Mandatory Increases and Decreases:

Mandatory Increases:	
Within grade increases........................	$ 86,000
Increased Social Security benefits..........	10,000
Increased cost of non-salary items..........	90,000
Subtotal Mandatory Increases................	186,000
Program Increase:	
Maintenance of current program levels.......	268,000
Total, Net Change................................	+$ 454,000

BEST COPY AVAILABLE

B. Drug Abuse Training
(Section 472 of the Public Health Service Act)

Budget Authority: 1987 Authorization: $260,000,000 which is shared with NIH.

	1986 Appropriation	1986 Available after Sequestering	1987	Increase or Decrease
Training	$ 1,500,000	$ 1,436,000	$ 1,355,000	-$ 81,000

Purpose and method of operation - In order to provide an adequate supply of scientists with the most up-to-date skills and expertise, NIDA sponsors drug abuse research training programs in the biomedical and behavioral sciences. Scientists with advanced knowledge of sophisticated research approaches are needed to carry out studies which will have a direct impact on prevention and treatment in communities with serious drug abuse problems.

NIDA's current program supports pre- and post-doctoral training in medical schools, universities and other institutions in the areas of basic, clinical, behavioral and epidemiological research. Specific areas of study include research on the genetic bases of drug abuse and mechanisms of action of opioid peptides; clinical studies of the effects of cocaine, marijuana, and sedative-hypnotics; and investigations of the effectiveness of various therapies in treating patients who abuse various combinations of drugs.

Drug Abuse Training By Type

	1985 Actual		1986 Available after Sequestering		1987	
	No.	Amount	No.	Amount	No.	Amount
Research Training						
Grants:						
Noncompeting	7	927,000	5	675,000	8	1,132,000
Competing	---	29,000	---	---	---	---
New	1	124,000	3	405,000	---	---
Supplemental	(2)	26,000	---	---	---	---
Subtotal	8	1,106,000	8	1,080,000	8	1,132,000
Fellowships:						
Predoctoral:						
Noncompeting	1	10,000	7	67,000	5	48,000
Competing	---	---	---	---	---	---
New	7	67,000	2	19,000	---	---
Supplemental	(1)	9,000	---	---	---	---
Subtotal	8	86,000	9	86,000	5	48,000

	1985 Actual		1986 Available after Sequestering		1987	
	No.	Amount	No.	Amount	No.	Amount
Postdoctoral:						
Noncompeting.........	5	99,000	12	246,000	8	175,000
Competing............	---	---	---	---	---	---
New..................	11	207,000	1	24,000	---	---
Supplemental.........	(1)	2,000	---	---	---	---
Subtotal...........	16	308,000	13	270,000	8	175,000
Total Fellowships....	24	394,000	22	356,000	13	223,000
Total Research Training..	32	1,500,000	30	1,436,000	21	1,355,000

Rationale for the Budget Request

The 1987 estimate will allow NIDA to continue the current program of pre-doctoral and post-doctocal training in drug abuse research. Training will be provided for 68 trainees, a reduction of 12 percent from the 1986 level. The level of support per trainee, for both stipend and non-stipend support, will be maintained at the 1986 level.

Continuing efforts include support for research training in the basic biological and behavioral processes relevant to investigations of the causes and effects of drug abuse, as well as epidemiologic and clinical research.

Number of Research Trainees

	1985 Actual	1986 Available after Sequestering	1987
Institutional Awards:			
Predoctoral............	22	22	22
Postdoctoral...........	33	33	33
Subtotal.............	55	55	55
Fellowships:			
Predoctoral............	8	9	5
Postdoctoral...........	16	13	8
Subtotal.............	24	22	13
Total:			
Predoctoral............	30	31	27
Postdoctoral...........	49	46	41
Subtotal.............	79	77	68

C. Drug Abuse Direct Operations
(Public Health Service Act, Section 301)

Budget Authority: Indefinite.

	1986 Appropriation	1986 Available after Sequestering	1986 Revised Estimate 1/	1987	Increase or Decrease
Dir Ops	$16,307,000	$15,606,000	$13,816,000	$14,183,000	+$ 367,000
FTEs			175	175	---

1/ This column excludes $2,491,000, of which $1,790,000 is a comparable transfer of Priority Disease Control and Research Projects (AIDS) to the Office of the Assistant Secretary; and, $701,000 is required to be reduced pursuant to the Balanced Budget and Emergency Deficit Control Act of 1985, P.L. 99-177.

Purpose and method of operation: The direct operations account supports planning, coordination, analysis, evaluation, and general administrative management servicer for the Institute's research and training programs. It also supports prevention, information dissemination, and epidemiological data analysis activities. These activities are supported through direct operating expenses and a limited number of contracts.

Prevention: The direct operations account is NIDA's sole source of support for efforts to stimulate and assist State, local and private sector involvement in drug abuse prevention services. For example, direct operations funds are used to support the development and dissemination of prevention campaigns such as the "Just Say No" Campaign. The "Just Say No" Campaign is directed at teenagers and their parents and involves the support of 500 community groups in the sponsorship of "Just Say No" Clubs. The formation of the first "Just Say No" Club was a spin-off of the Oakland Parents in Action organization, a minority community effort supported in part by NIDA. It is now the fastest growing prevention program in the country. In FY 1986 efforts are being made to increase the participation of minority communities in the campaign and to incorporate the program into elementary and junior high school programs.

A cocaine media campaign is also being developed, directed at 18 to 34 year olds, and will enlist the support of industry leaders in the development and distribution of radio, television and printed messages directed at employees, supervisors, employers, and families. Efforts will be made to reach high school and college students and to involve the music and sports industries, both of which can have a profound effect on the attitudes of young people, in the delivery of prevention messages.

One of NIDA's highest priorities is to mobilize various State, local, and private organizations who have demonstrated an interest in becoming more involved in drug abuse prevention. Current efforts include the National Prevention Network, a joint effort with the National Institute on Alcohol Abuse and Alcoholism and State prevention coordinators to provide a coordinated mechanism for sharing knowledge and resources in the prevention field; the Ethnic Family Initiative, which stimulates and assists the formation of local family groups in minority communities across the nation concerned with drug abuse prevention programs; a joint effort with Links, Inc., a national black women's service organization, to assist them in the development and operation of drug and alcohol abuse prevention programs for black youth; and a program with the Optimists International to help them develop and sponsor "Just Say No" Clubs.

NIDA has also initiated an effort to provide more information on the dangers of designer drugs. NIDA is producing pamphlets, brochures, and other materials appropriate to the various age groups at risk for these drugs and is providing technical assistance to State and local officials on the dangers and availability of various designer drugs. NIDA is also developing press releases, news bulletins, and conferences to inform the public of the dangers of these substances.

NIDA supports these efforts through the provision of technical assistance and a variety of other services. One of the most important of these is the development of prevention materials including pamphlets, books, and audiovisual materials. These include small pamphlets like the "Just Say No" flyer designed for distribution to adolescents and their parents, technical manuals on how to organize, operate and evaluate community prevention programs such as the "Prevention Evaluation Workbook," and a variety of films that can be used in prevention programs. NIDA encourages the distribution of these materials through the National Clearinghouse for Drug Abuse Information. Last year the Clearinghouse answered over 83,000 requests for information on drug abuse and distributed over 3 million publications in response to inquiries related to the "Just Say No" Campaign. NIDA is also providing training in the use of prevention evaluation strategies to encourage prevention programs to assess, and where appropriate, improve on their prevention programs.

AIDS: NIDA's efforts to reduce the spread of Acquired Immuodeficiency Syndrome (AIDS) is also supported with direct operations funds. Current efforts are focused on two major objectives: increasing the abilities of drug abuse counselors, health care professionals, criminal justice personnel, and other professionals who come into contact with intravenous drugs users to conduct AIDS prevention programs, and to diagnose and treat AIDS patients; and the development of effective prevention messages to reduce intravenous drug use.

Efforts will also be made to better inform professionals who come into contact with IV drug users on how to prevent and treat AIDS including the development of training manuals and audiovisual materials explaining the relationship between IV drug use and AIDS and how to diagnose and treat AIDS patients, sponsorship of workshops, and the provision of technical assistance to State and local organizations. Efforts to develop better prevention materials are especially important because of the high risk of transmission of AIDS between

IV drug users and their unusually high resistance to normal prevention materials. Programs currently in progress are attempting to develop novel approaches, such as targeting prevention messages toward the families or sexual partners of IV drug users, in attempting to improve the effectiveness of prevention programs.

In FY 1987, workshops will be conducted for persons associated with drug abuse service delivery, criminal justice administration, and health care to improve their understanding of HTLV-III testing, counseling of AIDS patients, and assisting AIDS patients in the health care system. Efforts will also be made to provide information on the precautions and strategies to be employed in working with HTLV-III positive patients in both residential and outpatient programs. NIDA will also work with national organizations representing State drug abuse agencies and local drug abuse treatment programs to assist in the development of policies at the State and local levels.

Epidemiology: While NIDA supports its major drug abuse epidemiological projects, such as the Drug Abuse Warning Network and the High School Senior Survey, with extramural research funds, much of the data processing costs associated with these projects are drawn from the direct operations account. This is especially true of special analyses involving unusual tabulations of data or cross tabulations of data from two or more studies to detect new trends or investigate unusual patterns. By maintaining an in-house data processing and analysis capability, NIDA can perform these services more quickly and at less expense than would be involved using outside services.

Rationale for the Budget Request

The FY 1987 request of $14,183,000 is $367,000 more than the FY 1986 estimate. These funds will be used for mandatory increases and decreases entailing a net increase of $380,000 and a program increase of $247,000 associated with a reduction for administrative overhead.

In accordance with Administration intent to focus all support for AIDS in the Office of the Assistant Secretary for Health, the funds earmarked for NIDA activities in this area have been transferred to OASH in 1987.

Mandatory Increases and Decreases:

Mandatory Increases:	
Within grade increases	$168,000
Increases FTS costs	5,000
Increased payments to Federal Employee Compensation Fund	10,000
Increased Social Security benefits	19,000
Increased cost for non-pay items	228,000
Subtotal Mandatory Increases	430,000
Mandatory Decreases:	
Reduction for Service and Supply Fund	- 14,000
Reduction for Standard Level User Charge	- 36,000
Subtotal Mandatory Decreases	- 50,000
Program Decreases:	
Reduction for administrative overhead	- 247,000
Program Increases:	
Maintenance of current program levels	+ 234,000
Total, Net Change	+$367,000

III. Alcoholism

	1986 Appropriation	1986 Available after Sequestering	1986 Revised Estimate 1/	1987 Estimate	Increase or Decrease
Research	$57,000,000	$54,550,000	$54,372,000	$56,618,000	+$2,246,000
FTEs			92	92	---
Training	1,500,000	1,436,000	1,436,000	1,327,000	-109,000
Direct Operations	11,658,000	11,157,000	11,157,000	10,876,000	-281,000
FTEs			110	110	---
Total	70,158,000	67,143,000	66,965,000	68,821,000	+1,856,000
FTEs			202	202	---

1/ This column excludes $178,000 which is required to be withheld by Section 515 of the Treasury, Postal Service, and General Government Appropriations Act, 1986.

Narrative

The National Institute on Alcohol Abuse and Alcoholism was established in 1971 in response to the enormous costs to the Nation of alcohol-related problems. The Institute supports a comprehensive program of extramural and intramural research and research training aimed at developing knowledge for improving treatment and preventing alcohol abuse and its tragic consequences. The Institute also fosters the effective use of research findings by disseminating new knowledge to the health care community and the public.

Alcohol problems in our society have reached a serious level. The adverse health consequences of alcohol abuse cover a wide range of impairments and disease, including physical, mental, and emotional disorders. Alcohol is involved in 100,000 deaths annually in the United States and is strongly associated with traumatic injuries, the leading cause of death and disability for persons under the age of 44. Approximately half of all fatal vehicle accidents involve alcohol, and drinking and driving is the leading cause of death for teenagers 15 to 19 years of age. Clinically significant alcohol-related problems are among the most prevalent of psychiatric diagnoses. The economic costs of alcohol problems in the United States continue to exceed $116 billion annually.

Substantial progress is being made in the fight against alcohol-related problems, and interest in the field of alcohol research continues to grow among scientists in many disciplines. Research is expanding our understanding of the biological mechanisms involved in alcohol abuse and alcoholism, and this new knowledge will ultimately find application in improved approaches to treatment and prevention.

Among the significant research developments is the confirmation that alcoholism often has a genetic basis, and that genetic predisposition to alcoholism may be accompanied by characteristic biochemical and electrophysiological markers that can be detected in the laboratory. The implications of these findings for the future of alcoholism prevention and treatment are striking. They open the prospect of using genetic markers to identify individuals at risk of alcoholism before the disease begins. They also point the way to better understanding of the basic processes that lead to alcoholism. An intensive search is underway to discover exactly which biochemical and cellular mechanisms are altered to create this predisposition and what those alterations are. Knowing exactly what is inherited to make individuals susceptible to alcoholism will increase our understanding of the mechanisms of alcoholism. Eventually it should become possible to use this knowledge to design new and highly individualized interventions to prevent or treat alcoholism.

Significant improvements in alcoholism treatment are also likely to emerge from recent research indicating that there are subtypes of alcoholism that may require different types and intensities of treatment. Alcoholism typology research, together with continuing advances in treatment evaluation methods, will lead to better matching of patients to treatment methodologies for greater cost-effectiveness.

Sophisticated new noninvasive technology is beginning to be applied in studies of the biological effects of alcohol. Among the most powerful techniques are two that are based on the physical phenomenon of nuclear magnetic resonance (NMR). The diagnostic and research capabilities of NMR are enormous. NMR spectroscopy can provide information about alcohol's perturbing effects on cellular metabolism and can allow measurement of changes in the amounts of critical cellular constituents without the need to open the body or remove tissue. NMR imaging can reveal internal anatomical changes produced by alcohol with clarity that is often superior to that with computerized tomography, and without the use of ionizing radiation. NMR technology, which will soon become available to NIAAA's intramural scientists with the completion of the new centralized NMR facility on the campus of the National Institutes of Health, will rapidly expand our knowledge of the mechanisms of disorders such as liver cirrhosis, cardiac damage, brain damage, the fetal alcohol syndrome, alcohol tolerance, and alcohol addiction.

Recent research indicates that alcohol affects every major component of the immune system, including cell-mediated immunity, which protects against viral infections. Research interest in the immunosuppressive effects of alcohol is increasing, partly because of the AIDS epidemic. It has long been known that heavy drinkers are more susceptible to bacterial infections, but little is known about alcohol's effects on resistance to viral infections. Nevertheless, as a precaution, many clinicians are now advising individuals at risk of exposure to the AIDS virus to avoid excessive drinking. There is a great need for more information on alcohol and the immune system. The effects of alcohol on immunity, particularly on resistance to AIDS, will receive increased emphasis in the NIAAA research program during the coming year.

a. Research
(Public Health Service Act, Section 301)

1987 Authorization: Indefinite

Budget Authority:

	1986 Appropriation	1986 Available after Sequestering	1986 Revised Estimate 1/	1987 Estimate	Increase or Decrease
Research	$57,000,000	$54,550,000	$54,372,000	$56,618,000	+$2,246,000
FTEs			92	92	---

1/ This column excludes $178,000 which is required to be withheld by Section 515 of the Treasury, Postal Service, and General Government Appropriations Act, 1986.

Purpose and Method of Operations

The goal of the NIAAA research program is to develop knowledge for improving the treatment and prevention of alcoholism and alcohol-related problems. The research is supported through grants to scientists throughout the Nation, the National Research Centers Program, contract studies in special areas of need, and an intramural program of biological and clinical research.

Alcohol's effects on the body's organ systems are complex, as are the social problems alcohol creates. These complexities require the Institute's support of research in a broad range of biological and behavioral sciences. Though systematic research on alcohol and its effects is a relatively new field, it is rapidly increasing our knowledge and understanding of one of the Nation's leading public health problems.

Significant advances have been made in our knowledge about the genetics of alcoholism. Observations of a genetic component in alcoholism have been substantiated by continuing epidemiological research, and other research continues to provide clues to the physiological and molecular basis of this genetic predisposition. For example, the young, nondrinking sons of alcoholic men have been found to have characteristic brain wave patterns. Other research has shown genetically based differences in the molecular structure of alcohol dehydrogenase and aldehyde dehydrogenase in alcoholics and nonalcoholics, and these variations in alcohol metabolizing enzymes are correlated with differences in the rate of alcohol metabolism. These findings raise the hope that specific pharmacological agents can eventually be developed to prevent the expression of the genetic predisposition to alcoholism.

There is also evidence that resistance to alcoholism may be inherited. Among the factors that may protect individuals from becoming alcoholic are genetically determined physical and chemical differences in the properties of enzymes for the metabolism of alcohol. Although the genes for these enzymes are present in all cells of the body, the major location for the enzymes themselves is the liver. Until recently, this localization of the alcohol metabolizing enzymes required a liver biopsy to assess the genotype of an individual. However, scientists recently have developed new procedures to assess the genetics of an individual's alcohol metabolizing enzymes from a small sample of either blood or skin. These procedures will facilitate genetic linkage analyses not only for alcoholism but for several other genetically determined psychopathologies as well.

Studies of brain neurotransmitter systems have found similarities between the neurochemical anomalies that are induced by alcohol and those that occur in some individuals displaying violent behavior or depression. Abnormally low levels of a metabolite of the neurotransmitter serotonin have been found in the cerebrospinal fluid of alcoholics, violent offenders, and depressed patients. In related studies, researchers are examining the effects of pharmacological agents that modify serotonergic neuron functions on the prevention of relapse in abstinent alcoholics. The results of such studies will improve not only the treatment of alcoholism, but also our understanding of the determinants of violent behavior and depression.

These are just a few examples of the recent advances in alcohol research. Rapid advances in our knowledge of alcohol and its effects are expected to continue as the NIAAA continues to support meritorious intramural and extramural research projects in every important area of alcohol research, from basic to clinical.

Funding levels for the NIAAA's research programs are as follows:

Research by Type of Award

	1985 Actual		1986 Available after Sequestering		1986 Revised Estimate 1/		1987 Estimate	
	No.	Amount	No.	Amount	No.	Amount	No.	Amount
Research Projects:								
Noncompeting..........	139	$15,902,000	172	$21,926,000	172	$21,926,000	196	$25,826,000
Competing:								
Renewal..............	27	2,946,000	26	3,912,000	26	3,912,000	26	3,117,000
New..................	73	8,231,000	74	7,193,000	74	7,193,000	48	4,304,000
Supplemental.........	(2)	178,000	(9)	338,000	(9)	338,000	(7)	254,000
Subtotal, Competing..	100	11,355,000	100	11,443,000	100	11,443,000	74	7,675,000
Subtotal, Research Projects..............	239	27,257,000	272	33,369,000	272	33,369,000	270	33,501,000
Other Research Mechanisms:								
Centers:								
Noncompeting..........	9	9,352,000	4	4,303,000	4	4,303,000	9	9,316,000
Competing.............	—	—	5	4,941,000	5	4,941,000	—	—
New...................	—	—	—	—	—	—	—	—
Supplemental..........	—	—	(1)	30,000	(1)	30,000	—	—
Subtotal............	9	9,352,000	9	9,274,000	9	9,274,000	9	9,316,000
Research Scientists:								
Noncompeting..........	16	889,000	16	874,000	16	874,000	19	1,037,000
Competing.............	1	54,000	2	108,000	2	108,000	2	108,000
New...................	1	41,000	3	139,000	3	139,000	3	139,000
Supplemental..........	(1)	24,000	—	—	—	—	—	—
Subtotal............	18	1,008,000	21	1,121,000	21	1,121,000	24	1,284,000
Small Business Innovation Research (Grants/Contracts):								
Noncompeting.........	—	—	—	—	—	—	1	150,000
Competing............	—	—	3	450,000	3	450,000	2	300,000
New..................	8	398,000	3	124,000	3	122,000	3	134,000
Supplemental.........	—	—	—	—	—	—	—	—
Subtotal..........	8	398,000	6	574,000	6	572,000	6	584,000
Small Grants (new).....	9	205,000	10	227,000	10	229,000	10	227,000

1/ This column excludes $178,000 which is required to be withheld by Section 515 of the Treasury, Postal Service, and General Government Appropriations Act, 1986.

	1985 Actual		1986 Available after Sequestering		1986 Revised Estimate 2/		1987 Estimate	
	No.	Amount	No.	Amount	No.	Amount	No.	Amount
Cooperative Agreement:								
Noncompeting	—	—	—	$36,000	—	$36,000	—	$25,000
Competing	—	—	—	—	—	—	—	—
New	—	$26,000	—	—	—	—	—	—
Supplemental	—	—	—	—	—	—	—	—
Subtotal	—	26,000	—	36,000	—	36,000	—	25,000
Contracts:								
Renewal	13	1,867,000	7	1,134,000	7	1,134,000	10	1,778,000
New	3	312,000	5	218,000	1	40,000	—	—
Subtotal	16	2,179,000	12	1,352,000	8	1,174,000	10	1,778,000
Subtotal, Other Research Mechanisms	60	13,168,000	58	12,584,000	54	12,406,000	59	13,214,000
Total, Extramural Research	299	40,425,000	330	45,953,000	326	45,775,000	329	46,715,000
Intramural Research								
Personal Services	—	3,082,000	—	3,356,000	—	3,356,000	—	3,451,000
Other Objects	—	2,526,000	—	2,787,000	—	2,787,000	—	2,802,000
Payments to NIH	—	2,476,000 1/	—	2,454,000	—	2,454,000	—	3,650,000
Total, Intramural Research	—	8,084,000	—	8,597,000	—	8,597,000	—	9,903,000
Total, Research	299	48,509,000	330	54,550,000	326	54,372,000	329	56,618,000
(FTEs)		(86)		(92)		(92)		(92)

1/ The amount reflects a comparable reduction of $276,000 for the NIH Management fund costs.

2/ This column excludes $178,000 which is required to be withheld by Section 515 of the Treasury, Postal Service, and General Government Appropriations Act, 1986.

Rationale for the Budget Request

The 1987 request will support an estimated 270 project grant awards, approximately the same level as 1986. The estimate will allow 74 new and competing grants, reflecting a decrease of 26 awards from the 1986 level. However, this decrease is offset by a significant increase in the number of noncompeting awards. The funds requested for the 270 grants is based on the assumption that research costs will increase by 4 percent each year, in 1986 and 1987. The 4 percent increase is applied to direct costs only. The estimate reflects anticipated savings in indirect costs as a result of a reduction in the administrative costs allowed as indirect costs.

The 1987 request will support research projects in a broad range of subjects which hold promise for productive alcohol research. The research program is planned as follows:

Research by Program Distribution

	1985 Actual	1986 Available after Sequestering	1986 Revised Estimate 2/	1987 Estimate
Extramural Research				
Genetics and Molecular Biology..................	$2,904,000	$3,406,000	$3,406,000	$3,475,000
Biochemistry and Metabolism..............	2,360,000	2,683,000	2,683,000	2,709,000
Neurosciences............	6,488,000	7,221,000	7,221,000	7,236,000
Behavioral and Environmental Antecedents......	5,139,000	5,693,000	5,693,000	5,710,000
Safety and Trauma........	971,000	1,139,000	1,139,000	1,153,000
Alcohol and Pregnancy....	2,933,000	3,255,000	3,255,000	3,288,000
Alcohol-Related Medical Disorders...............	8,331,000	9,253,000	9,253,000	9,330,000
Incidence and Prevalence.	3,206,000	3,529,000	3,351,000	3,419,000
Treatment................	4,606,000	5,810,000	5,810,000	6,350,000
Prevention...............	3,487,000	3,964,000	3,964,000	4,065,000
Subtotal...............	40,425,000	45,953,000	45,775,000	46,715,000
Intramural Research				
Clinical Investigations..	5,070,000	5,307,000	5,307,000	6,449,000
Metabolism Research......	1,185,000	1,293,000	1,293,000	1,358,000
Preclinical Studies......	1,111,000	1,213,000	1,213,000	1,273,000
Neuroadaptive Processes..	718,000	784,000	784,000	823,000
Subtotal...............	8,084,000 1/	8,597,000	8,597,000	9,903,000
Total, Research...........	48,509,000	54,550,000	54,372,000	56,618,000

1/ The amount reflects a comparable reduction of $276,000 for the NIH Management fund costs.

2/ This column excludes $178,000 which is required to be withheld by Section 515 of the Treasury, Postal Service, and General Government Appropriations Act, 1986.

Genetics and Molecular Biology

Alcoholism is a disorder characterized by a persistent and progressive pattern of abnormally intense alcohol-seeking behavior which, over time, results in a narrowing of interest in activities other than those related to drinking, loss of control over drinking, and the development of tolerance and dependence. We now know that alcoholism and several responses to alcohol are influenced by genetic factors. Genetically influenced responses include alcohol preference, alcohol elimination rate, sensitivity of the brain and other organ systems to alcohol, development of acute and chronic tolerance to alcohol, development of physical dependence, and severity of withdrawal symptoms.

Research is underway to learn what physical characteristics people inherit that make them vulnerable to develop the alcoholic behavior pattern and how the anatomical, physiological, and biochemical systems of susceptible individuals differ from those of individuals who are not susceptible.

One of the most promising strategies in the search for genetic markers of vulnerability to alcoholism is to study large numbers of healthy young men at high risk for alcoholism because they have an alcoholic parent. To be of value the trait markers must be detectable before the onset of the illness and remain observable during periods of remission. Some of the most significant findings in the search for possible biological factors associated with high risk for alcoholism have come from investigations of various neurophysiological parameters in high-risk and low-risk subjects. Faster electroencephalographic (EEG) brain activity has been recorded in 11- to 13-year-old sons of alcoholics when compared to low-risk subjects. Fast EEG activity is also frequently found in abstinent alcoholics. It was observed that high-risk subjects exhibited greater increases of slow alpha energy, greater decreases of fast alpha energy and total mean alpha frequency compared to low-risk subjects. These electrophysiological results are interesting in light of several research findings indicating that the effects of alcohol on the electroencephalogram are largely determined by genetic factors.

Investigators have more recently studied evoked brain potentials in children of alcoholics. These studies were undertaken to investigate the possibility that sons of male alcoholics manifest brain aberrations that antedate any exposure to alcohol and are similar to some of the electrophysiological deficits observed in abstinent alcoholics. Young males 6 to 14 years of age were selected as subjects so that strict criteria of inexperience with alcohol and other drugs could be imposed. Only boys whose fathers received a medical diagnosis of alcoholism were included in the high-risk group. The research showed that one component of the event-related potential (ERP) was significantly reduced in high-risk boys. In addition, the group ERP waveform in sons of alcoholics was markedly similar to ERP waveforms in abstinent alcoholics.

These preliminary biological data are most encouraging because they were found in a group of subjects known to be significantly at risk for alcoholism. The Institute will encourage future investigations to establish the generalizability of current results to women, as well as to different ethnic and socioeconomic groups. Longitudinal research will also be encouraged to determine whether the variables differentiating high-risk from low-risk individuals are predictive of subsequent alcohol abuse. Such longitudinal studies represent an important step in identifying a marker of genetic susceptibility to alcoholism.

Research will also be continued on genetic variations in the enzymes of alcohol metabolism. Between-individual variation in alcohol elimination rates is as large as 300 percent, and at least 40 percent of this variation is attributable to genetic factors. We do not yet know whether the genetic variation in alcohol elimination rate relates to genetic susceptibility to alcoholism. Research opportunities exist for genotyping alcohol dehydrogenase polymorphism and determining how genetic polymorphism of alcohol dehydrogenase relates to susceptibility to alcoholism. The recent advances in the molecular biology of this enzyme have made this goal attainable in the near future.

Continued study of the genetics of alcoholism is critically important for economic as well as medical reasons. Effective primary prevention depends on the ability to identify individuals who are genetically vulnerable for the future development of alcoholism. Thorough understanding of genetic risk factors in alcoholism could lead to more precise and more effective targeting of major prevention efforts to the individuals who are most vulnerable. Detailed knowledge of genetic mechanisms in alcoholism could lead to more appropriate treatment regimens that take into account the uniqueness of individuals as products of both heredity and environment.

Biochemistry and Metabolism

Among the most promising opportunities for research on the biology of alcoholism are those for investigating the metabolism of alcohol. Three major systems for the metabolism of alcohol have been identified: the alcohol dehydrogenase (ADH) system, the catalase system, and the microsomal ethanol oxidizing system (MEOS). Although the ADH system is thought to be predominant, research on all three systems is encouraged to answer questions about their relative contributions to overall alcohol metabolism and the biological significance of each. Additional research is needed, for example, on the biochemical mechanisms of the MEOS. This pathway depends on a substance called cytochrome P-450, which occurs in many other microsomal enzyme systems involved in the metabolism of foreign substances, including drugs and carcinogens. Depending on the foreign chemical, P-450 metabolic actions can yield a product that is more carcinogenic or more toxic to the liver than the original compound.

Since P-450 enzymes are involved in steroid, vitamin A, and foreign chemical metabolism, and since many of them can act on more than one substance, research is needed to determine whether the alcohol-induced form, in addition to metabolizing alcohol, might act on those other substances. If such activities can be demonstrated, it could help explain some of the medical consequences of alcoholism. For example, alcoholics commonly have endocrine disturbances and vitamin A deficiency, both of which might be due to degradation of those substances by alcohol-induced P-450. Likewise, if it can be demonstrated that alcohol-induced P-450 can convert carcinogenic chemicals into more powerful carcinogenic products, this could explain why alcoholics are more prone to certain kinds of cancer than the general population.

The body breaks down alcohol into simpler substances by a series of metabolic steps. Although there are at least three pathways for the initial step in alcohol metabolism, all yield the same product: acetaldehyde. The body's capacity to break down this intermediate product is vital, because acetaldehyde is highly toxic. The enzyme that usually performs this second major step is called an aldehyde dehydrogenase (ALDH). Research has identified several different ALDH enzymes. They each perform the same metabolic function but differ in some physical and chemical properties, which implies that they differ somewhat in chemical structure. These differences may help to explain changes in reaction to alcohol after long-term abuse. Research will be continued to isolate and purify the different ALDH enzymes, or isozymes. One aim of the work is to identify the parts of each isozyme that bind to the acetaldehyde and the parts that interact with other substances that regulate the enzyme's activity. Because current treatments of alcoholism use drugs that block or enhance the activity of ALDH, a better understanding of the differences in ALDH isozymes is important for improving these treatments.

Neurosciences

Because of the known behavioral effects of alcohol, it is clear that the underlying basis of intoxication, tolerance, and dependence resides in a disruption of nervous system function, most likely in the brain. Studies in the neurosciences have focused primarily on nerve cell membranes and neurotransmission. Alcohol consistently affects the lipoprotein membrane of nerve cells, altering the fluidity and biochemical properties of the membrane. These disordering or fluidizing effects of alcohol are major effects of this drug class.

A growing area of research is on the role of membrane changes in several phenomena associated with alcohol intake, including intoxication, alcohol tolerance, physical dependence, and the withdrawal syndrome. The focus of these studies is the cell membranes of the central nervous system, since membrane phenomena are intimately involved in neurotransmission. Behavioral signs of alcohol intoxication may reflect altered neurotransmission caused by disordering of nerve cell membranes. Alcohol tolerance from long-term consumption may be related to adaptive changes in membrane structure that compensate for the disordering caused by alcohol. Physical dependence, manifested as craving for alcohol, may reflect the need of alcohol-adapted nerve cell membranes to have alcohol present in order to maintain the correct degree of membrane fluidity. Finally, the acute reactions associated with alcohol withdrawal may result from the sudden development of excessive rigidity, and consequently impaired neurotransmission, in alcohol-adapted nerve cell membranes when alcohol is no longer present.

Research will continue on the mechanisms by which alcohol produces adaptive responses in nerve cells. Further research is needed on the effects of alcohol on the chemical composition of nerve cell membranes, the enzymes involved in metabolism of membrane phospholipids, the production of other lipid constituents of membranes, and activities of key membrane enzymes involved in the transport of substances through the cell membrane. Since alcohol is known to affect some membranes more than others, research using various kinds of cell membranes is needed to understand the basis for this difference in response. This research will contribute to our understanding of the molecular mechanism of alcohol intoxication and tolerance development. Understanding of how alcohol produces adaptive responses in nerve cells, and why these responses are greater in some individuals than in others, may lead to more effective treatment of alcoholism and more effective measures of the pathology caused by cellular adaptation to alcohol. Such knowledge could lead to more effective treatment of alcoholism as well as to new methods for counteracting the damaging effects of cellular adaptation to alcohol.

Research will also be encouraged on the similarities between alcohol-induced cellular changes and those associated with aging. These similarities have led to a hypothesis that alcohol abuse may accelerate the aging process. One similarity is an increase in the ratio of cholesterol to phospholipids in the brain cell membranes near the synapses, junction areas where nerve cells interact. In the case of chronic alcohol consumption, this change is thought to counteract the fluidizing effect of alcohol, contributing to the development of tolerance. Another similarity between alcoholism and aging is a decreased responsiveness by cells in the hippocampal region of the brain to acetylcholine, a neurotransmitter involved in memory and other basic cognitive processes. The decrease in acetylcholine activity probably plays a role in memory loss, dementia, and other cognitive dysfunctions associated with both alcoholism and aging. Further research in this area may lead to a better understanding of the role of alcohol abuse in the development of memory loss and impaired cognition in the elderly. As the proportion of elderly persons in the population increases, an understanding of the possible role of alcohol abuse in aggravating cognitive impairments associated with old age becomes increasingly significant to public health.

Studies have shown that alcohol can produce changes in neurotransmitter turnover and concentration in the brain. The major focus in these studies has been on the catecholamine neurotransmitters. While additional research is needed on alcohol's effects on these neurotransmitters, other neurochemicals, including amino acids and neuropeptides, also need to be investigated.

Research will be encouraged on neurotransmitters known to be present in specific brain areas that are affected by alcohol, as determined by behavioral changes. In particular, the cortex, cerebellum, brainstem reticular formation, hippocampus, and hypothalamus need to be methodically analyzed. Studies on neurochemical changes during prolonged alcohol intoxication, during withdrawal, and after withdrawal will also be emphasized. Efforts to learn about alcohol's intoxication mechanisms and to determine the brain areas and chemicals that are primarily affected by alcohol may ultimately result in the development of more rational therapies and more effective ways to prevent alcoholism.

Behavioral and Environmental Antecedents

Research on psychological, cultural, and environmental factors that influence drinking is leading to new ideas about the causes, pathology, treatment, and prevention of alcohol abuse and alcohol dependence.

Much of the research in this area over the past decade has focused on the use of alcohol in the family environment. Studies have investigated the normal use of alcohol as well as its problematic use. Of special importance is the study of environmental and psychological factors that may promote the transmission of alcohol abuse from one generation to the next. Studies are continuing to analyze how children are introduced to drinking and family attitudes, beliefs, and practices of drinking. Research to understand controls that exist within the family to establish acceptable drinking behavior on the one hand and unacceptable behavior on the other may provide new information about the development of alcoholism. While there is considerably increased risk for children of alcoholics, it is well documented that not all of them develop drinking problems. Identification of the protective factors in such cases could provide important leads in developing prevention and intervention strategies for children at risk of alcoholism.

Because so many alcohol abuse problems develop during adolescence, researchers are studying how young people begin to drink. Alcohol abuse is a visible problem in school-age children and is associated with many other problem behaviors in this population, such as low self-esteem, poor academic performance, school dropout, violence, truancy, running away, depression, and anxiety. Research that studies young people over time and considers the influence of the child's family and peer group will be encouraged.

Research will also continue on cultural influences on drinking, and the natural history of alcoholism. Such research can provide clues, not only to the risk factors associated with problem drinking, but also to cultural factors that minimize the likelihood of problem drinking. Researchers are also recognizing that alcohol is a problem for both men and women and have begun to include both sexes in their research protocols in order to examine the differential effects of alcohol use.

Research will also continue on the relationship between occupational factors and alcohol abuse. The work environment provides many Americans with their primary interactive and socializing experience. Some jobs, however, seem to be identified with heavy drinking and alcohol abuse. Work conditions and interpersonal relationships while at work seem to play an important part in defining drinking patterns for employees. Further research is needed on the influence on drinking of stress, physical discomfort, boring work, prolonged or extended work, dangerous work, and meticulous work. Findings in this area can have important implications for the development of more effective interventions within the workplace.

Safety and Trauma

Trauma is a major health problem in the United States. Injuries kill more Americans aged 1-34 than all diseases combined, and they are the leading cause of death up to age 44. Accidents and other traumatic injuries now rank as the fourth leading cause of death in the United States, outranked only by heart disease, cancer and stroke. The total cost of these injuries is more than $75 billion a year. Numerous studies have indicated that alcohol is the principal agent involved in major forms of trauma. Alcohol is involved in about 20 percent of automobile crashes with a serious injury to an occupant. It is involved in about 50 percent of all fatal automobile crashes. A high proportion of private aircraft accidents, recreational boating accidents, burns, falls, suicides, and homicides also involve alcohol intoxication.

Very little research has been done in the area of alcohol-related trauma, although trauma medicine is emerging as an important medical specialty and it is known that alcohol is a factor in a high percentage of trauma cases. Emphasis will be placed on studies designed to determine the impact of alcohol on the severity of injury, the effects of alcohol on the body's ability to recover from injury, and the interactions of alcohol with medications and medical procedures commonly used in the treatment of trauma.

Additional research is needed on the relationship between alcohol abuse and fractures. One recent study indicated that problem drinkers present fracture patterns resembling those common among the elderly, such as multiple fractures, delayed healing, increased osteoclastic activity, reduced bone mass, and ischemic bone necrosis. Other investigations have indicated that alcohol abuse may be equivalent to smoking as a factor in the development of osteoporosis and that long-term alcohol abuse is detrimental to skeletal integrity. Research is needed to investigate the possibility that chronic alcohol abuse may disrupt calcium homeostasis and predispose the skeleton to fracture.

Another important area for additional research is the possible effects of alcohol as a detrimental factor in the defense mechanisms to blood loss. Acute blood loss is frequently the cause of death in accident victims, and acute blood loss in intoxicated patients is a common medical emergency. Some studies have indicated that alcohol decreases survival from an otherwise sublethal hemorrhagic stress. Physiological, biochemical, and pharmacological studies are needed to elucidate the mechanisms of hemorrhagic shock during acute intoxication and in chronic alcoholic subjects. Specifically, studies are needed in cardiovascular physiology, cell membrane function, electrolyte metabolism, general metabolism, and endocrinology. Studies are needed to clarify the effects of the autonomic nervous system in such subjects. Experimental studies are needed to ascertain what form of treatment can prevent death in such subjects.

Alcohol and Pregnancy

Maternal alcohol consumption during pregnancy increases the risk of birth defects in offspring, ranging from subtle behavioral abnormalities to the severe mental retardation and physical deformities of the fetal alcohol syndrome (FAS). Estimates of the incidence of FAS range from 1 to 3 per 1000 live births. The incidence of alcohol-related birth defects less severe than the full FAS is much greater.

The Institute supports both human longitudinal studies and laboratory research on the effects of alcohol on the developing fetus. Key issues being addressed are the levels of alcohol consumption during pregnancy that pose a threat to the fetus; and whether drinking is riskier at some phases of pregnancy than at others. New infant assessment instruments and procedures have been developed recently which enable identification of important but more subtle neurological and behavioral impairments at a much younger age. These procedures permit much more efficient and economical correlation of maternal alcohol use and infant neurological deficiencies.

One ongoing longitudinal study has examined nearly 500 infants at birth, at 8 and 18 months, and at 4 and 7 years of age. Although data from the 7-year evaluation are still under analysis, some intriguing results have already been reported from the study. The study has found several neurological and behavioral deficits in children whose mothers consumed alcohol either lightly, moderately, or heavily during pregnancy. These deficits were measurable from the first day of life, have persisted until at least 4 years of age, and on most measures are proportional to the amount of alcohol their mothers consumed during pregnancy. The data gathered so far do not suggest a threshold level of "safe" alcohol consumption during pregnancy, but rather suggest that even light drinking during pregnancy may have adverse effects. The Institute will continue to support this and other longitudinal studies with the goal of gaining a better understanding of the complex interactions and effects of prenatal alcohol exposure on the health and development of exposed children.

Laboratory research on the mechanisms of alcohol-induced fetal injury will also be continued. An important aspect of this research is the investigation of alcohol-induced injury to the central nervous system. The developing brain can be injured in various ways that are related to time of exposure to alcohol. The general sequence of brain development suggests there are two periods when the central nervous system is particularly vulnerable. Of particular concern is the "brain growth spurt," which is the period when the brain is growing most rapidly. This period includes the third trimester of pregnancy and the first 18 months of postnatal life. Toxic agents, including alcohol, administered during the third trimester may produce alterations in the relationships between nerve cells. Research will be encouraged to determine the effects of alcohol exposure on various areas of the brain, including the hippocampal formation and the cerebellum, in order to determine the mechanisms of alcohol-induced central nervous system injury in the developing fetus.

Researchers are also investigating the extent to which other factors interact with alcohol exposure to increase the risk for fetal damage. Some studies have suggested that fetal malnutrition may play a significant role in fetal damage. The fetal malnutrition is not necessarily caused by maternal undernourishment but may also be caused by impaired absorption and distribution of nutrients in a woman who is receiving an adequate diet and is also drinking. Malnutrition, so common in alcoholics, coupled with impaired transport of nutrients through the placenta, may contribute significantly to fetal injury. Among the nutrients under study are the trace mineral zinc, the vitamins thiamine and folate, and amino acids such as leucine. Research has already demonstrated that severe zinc deficiency in mothers retards fetal growth and causes malformations of the central nervous system that are similar to those of fetal alcohol syndrome. Since zinc deficiency is prevalent among chronic alcoholics, researchers are investigating the effects of maternal drinking coupled with restricted zinc intake on the developing fetus. If it can be demonstrated that alcohol ingestion and restricted zinc intake act together to produce biochemical brain changes by inhibiting the movement of zinc through the placenta, the hypothesis that fetal malnutrition contributes to the development of FAS will be supported. The outcome of this research and other studies of nutritional factors could have important implications for the development of therapeutic interventions during pregnancy.

Alcohol-Related Medical Disorders

There is growing recognition that alcohol abuse contributes significantly to the overall burden of illness. Alcohol abusers are at higher risk than other individuals for many forms of illness. They experience more days of illness, more days absent from work due to illness, and their hospital care tends to be more lengthy and more costly. Alcohol consumption is associated with a wide range of debilitating and often fatal disorders, including liver and other gastrointestinal disease, cardiomyopathy, diabetes, several forms of cancer, hypertension, and brain damage.

An area of major emphasis in 1987 will be the study of alcohol's effects on the immune system, with emphasis placed on alcohol's effects on cell-mediated immunity. The knowledge to be gained may be crucial to our understanding of the role of alcohol in the development of AIDS and other infectious diseases. Answers are needed to critical questions such as these: Does alcohol intoxication increase the likelihood of AIDS infection in individuals exposed to the virus? Does it increase the risk of active AIDS developing in persons who have the virus but are asymptomatic?

Research on the effects of alcohol on the neuroendocrine system will also be emphasized. Alcohol has been shown to both stimulate and suppress hormones secreted by the neuroendocrine system. These hormones have a crucial role in the regulation of growth and maturation, metabolism, reproductive function, and responses to stress. For example, although it has long been known that there are relationships between alcohol abuse, stress, and depression, it has only recently been discovered that interactions between these three conditions are mediated in part by alcohol's effects on hypothalamic, pituitary, and adrenal hormones. Alcohol stimulates release of hormones from the hypothalamic-pituitary-adrenal system. These hormones are also secreted during stress and temporarily act to reduce or alleviate tension. It is not yet known how this hormonal system adapts to the stress of chronic alcohol abuse. Further research is needed to clarify these interactions.

The Institute will also continue to place emphasis on studies to understand the effects of alcohol abuse on the brain. Chronic alcoholism is associated with a broad spectrum of brain disturbances ranging from the severe symptoms of the Wernicke-Korsakoff syndrome to more subtle cognitive disturbances that are found in a majority of alcoholic patients. Subclinical brain damage might impair the ability of some individuals to reduce their intake or abstain from alcohol, and it could account for such phenomena as loss of control. These subtle forms of brain damage are important to assess, because their presence and early detection may alter prognosis and treatment.

Two new technologies, computerized tomography (CT) and brain electrophysiology involving evoked potentials (EP) and event-related potentials (ERP), have made it possible to examine subtle brain damage in alcoholics noninvasively. CT scanning, which allows structural changes in the brain to be visualized on a computer screen, has demonstrated that brain atrophy is present in many alcoholics, and that the damage is not as localized as had been previously thought. The highly sensitive EP and

ERP techniques have revealed subtle electrophysiological changes in the brains of alcoholics that reflect functional disturbances in integrative processes as well as damage to various neuroanatomical systems. These studies show that the brain is a major target for the actions of alcohol.

Brain electrical phenomena change in response to acute or chronic intoxication, neurotoxicity, tolerance, physical dependence, hangover, and withdrawal, and changes persist after long-term abstinence. It is not known, however, whether the brain dysfunction and damage are the direct result of neurotoxicity from alcohol or its metabolite acetaldehyde, or whether these effects are produced by indirect effects of factors that accompany alcoholism. Further research is needed to determine the underlying mechanisms of damage; to learn whether the brain disturbances in recovered alcoholics are indeed permanent; and to understand the role of associated factors such as duration of alcohol abuse, amount consumed per sitting, number of withdrawals, nutritional deficiencies, and family history of alcoholism. It is also possible that genetic factors enhance susceptibility to both alcoholism and brain damage from alcohol, as suggested by the puzzling fact that some alcoholics develop severe central nervous system deficits, while others with similar medical and drinking histories seem resistant to these effects of alcohol.

Continued investigation of these alcohol-related brain dysfunctions is critically important for gaining a better understanding of the mechanisms and causes of alcoholism. Furthermore, by identifying the exact nature and causes of brain deficits in chronic alcoholics, such studies could lead to better treatment and prognosis of individual alcoholics.

Incidence and Prevalence

The Institute's program of epidemiological research studies distributions and trends in the rates of alcohol-related problems in the context of patterns of drinking and abstention in the general U.S. population. The purpose of the program is to provide a base of current data for charting prevalence and monitoring change, to describe patterns and interactions related to alcohol problems and dependence and their prevention, and to study trends in treatment systems and other societal responses to alcohol problems. Analyses are carried out in the population at large, in special subgroups, and in clinical populations.

In the past year, initial results have become available from several sources on national patterns and trends in drinking practices and problems. Sales statistics for 1984 show that per-capita consumption of alcohol from all beverages fell by 1.5 percent compared with 1983, continuing a downward trend that began after 1981. This short-term trend, however, comes in the wake of very substantial increases in per-capita consumption in earlier years. A recent comparison of national survey data from 1984 with similar data from 1967 suggests that the increase in per-capita consumption over this period reflects neither a change in the proportion of drinkers in the population nor a change in the frequency of drinking, but rather an increase in the proportion of the population drinking relatively substantial amounts per occasion.

New nationwide studies of drinking patterns and problems in minority populations have shown substantial divergences from patterns in the overall population. The black population shows a substantially higher proportion of abstainers and a generally later age of commencing drinking than the general population. While heavy drinking among males in the general population is concentrated in the late teenage years and early 20s, heavy drinking among black males tends to start later and to persist longer. These differences may help explain the large excess mortality from alcohol-related cirrhosis among blacks. Among Hispanics, heavy drinking also seems to persist to later ages than in the general population, with higher rates of heavy drinking among Mexican-Americans than among other Hispanic groups. Many Hispanic women abstain, and relatively few are heavy drinkers, but drinking is strongly associated with acculturation to the general American society.

These findings, along with a variety of other data on the prevalence and special characteristics of alcohol problems in different minority populations, were reviewed at a recent NIAAA-sponsored conference on alcohol and American minorities. The studies presented at the conference underlined the diversity of drinking patterns and problem rates in our multicultural society.

The Institute's Alcohol Epidemiology Data System has recently published a series of three data reference manuals, presenting detailed data from recent years on apparent alcohol consumption, liver cirrhosis mortality, alcohol problem indicators for U.S. counties, and alcohol-related hospital discharges. An additional data reference manual on alcohol-related hospital discharges is being prepared. Associated analyses have shown that cirrhosis mortality has been declining throughout the Nation since the mid-1970s, with nonalcohol-related cirrhosis decreasing faster than alcohol-related. There are some signs of decline in other alcohol-related causes of death, beginning about 1980.

Treatment

Dramatic changes have occurred in the alcoholism treatment system in the United States over the past decade. The trends include changes in reimbursement policy; expansion of inpatient treatment as a major component of the health service industry; growth of Alcoholics Anonymous; and the emergence of nontraditional sources of recruitment into treatment, such as employee assistance programs and drinking driver programs.

Between 1978 and 1983 there was a 58 percent increase in the number of hospital inpatient units treating alcohol and other drug dependency patients. During this time there was also a major redistribution of the share of hospital inpatient treatment beds held by the three main sectors of the alcoholism treatment industry. For-profit institutions showed the greatest proportionate growth, from 5 percent to 16 percent, probably in response to changes in insurance reimbursement. The share of patients treated by nongovernmental, not-for-profit institutions also increased from 31 percent to 41 percent, while the number of units affiliated with State, local, and Federal governments declined from 64 percent to 43 percent.

In addition, there has been significant expansion of other parts of the treatment system. Of the approximately 290,000 patients registered as inpatients on September 30, 1982, or outpatients in that month in 1982, 18 percent were in 24 hour care program facilities. The majority, 72 percent, were being treated in outpatient programs.

There has also been a marked trend toward diversification and specialization. Early counseling or referral to specialized treatment is increasingly prevalent in employment settings and health maintenance organizations. Inpatient and outpatient programs are targeting their services at special population groups such as the military, adolescents, children of alcoholics, employee groups, and women. Media advertising is being used to promote program utilization in many parts of the country. Despite tremendous increases in the availability and scope of alcoholism treatment services, there is also a trend toward the homogenization of therapeutic approaches around a dominant rehabilitation model consisting of detoxification, alcohol education, group confrontational therapy, Alcoholics Anonymous meetings, and disulfiram therapy.

Although there are practical difficulties involved in treatment research, some notable achievements have been made in recent years. Significant advances in the technology of assessment have led to new techniques for screening and diagnosis. The combined use of biochemical tests, clinical examination, and self-report questionnaires, especially when used in conjunction with behavioral indicators such as alcohol-related accidents, impaired job performance, and drunk driving, now make it feasible to identify large numbers of problem drinkers who could benefit from early intervention. Ongoing studies are leading to improved diagnostic criteria and to new diagnostic instruments capable of confirming alcohol dependence reliably and quickly. Rapid improvements in differential assessment technology allow the full spectrum of alcohol-related disabilities to be determined, to guide the development of systematic alcoholism treatment plans.

Some notable advances in basic research have begun to stimulate new approaches to treatment and patient placement. New procedures to measure the severity of alcohol dependence may soon make it possible to assign patients to different types and intensities of treatment, based on their vulnerability to readdiction. Investigation of psychological expectancies, such as beliefs about the disinhibiting effects of alcohol, has shed new light on the complex mechanisms underlying the disruptive effects of alcohol on behavior, particularly in individuals with antisocial personality traits. These mechanisms may lead to the development of more appropriate treatment interventions designed to prevent the recurrence of domestic violence, sexual assault, and other types of alcohol-related deviance. One of the most promising areas of basic research that has benefitted greatly from the development of new assessment technologies is the identification of alcoholic subtypes. Some evidence suggests that psychopathology and a family history of alcoholism are associated with poor prognosis, and that these types of patients therefore may require more intensive treatment. Other data indicate that married, socially stable patients who develop alcoholism later in life respond better to treatment. This type of patient may be a good candidate for less intensive treatment.

Finally, advances in treatment evaluation methods allow a more accurate estimation of the relative contributions of client characteristics, therapeutic interventions, program settings, and environmental variables to the success or failure of treatment. Improvements in assessment and evaluation technologies have contributed to new knowledge about the overall efficacy of alcoholism treatment and the relative cost-effectiveness of different intensities and types of treatment. For example, recent research has shown that alcoholism treatment reduces the patient's demand for health services, and that less expensive forms of treatment such as day hospital care and outpatient visits may be as effective for some patients as residential care.

The most pressing treatment research questions are in the area of patient placement, for example, the optimal length of stay in residential facilities, the relative efficacy of different therapies, the appropriateness of inpatient versus outpatient program settings for different types of patients, and the ideal mix of services ranging from detoxification to aftercare. Emphasis will be placed on applied research to prepare the way for clinical evaluations. Needed applied research includes development of a differential assessment battery capable of measuring relevant patient characteristics and treatment variables, methods to evaluate the short-term impact of different treatment components, and better techniques to monitor compliance with various treatment regimens.

Prevention

The Institute's prevention research program is aimed at finding effective and practical measures to reduce problem drinking. There are increasing demands from States, communities, and citizen groups for information on which to build sound, effective prevention programs. There are also major movements at the State level to amend legislation relating to alcohol use and information is needed on the impact of such changes on the incidence of alcohol problems. Progress is being made in establishing a base of knowledge about the prevention of alcohol problems, and this knowledge is being disseminated and used throughout the country. However, many questions remain unanswered.

Research is making it increasingly clear that, given the complexity of factors influencing drinking behavior and the wide range of drinking problems, the most promising prevention strategies are those that combine a variety of approaches targeted both to the individual and to the environment. The Institute will continue research to learn what interventions and policy changes can prevent alcohol-related problems and how these approaches can most effectively be combined into comprehensive prevention strategies.

Special emphasis is placed on studies related to alcohol abuse prevention among adolescents and preadolescents. Recent data indicate that children are experiencing pressure to use alcohol as early as the fourth grade. These disturbing trends, together with the fact that a significant portion of adult alcoholics began using alcohol as children, have spurred research to develop improved prevention programs for use with earlier age groups.

One such study is evaluating the effectiveness of an alcohol abuse prevention program for fifth and sixth graders. The program is based on social learning theory, which postulates that to prevent people from adopting an undesirable behavior it is necessary to first expose them to the negative argument or model, then present a strong counterargument and extensive opportunity to practice techniques for resisting pressure. This technique has been successfully applied in the prevention of cigarette smoking. The intervention is designed to provide students with the social skills necessary to resist societal and peer group pressures to use alcohol by giving them information on how to do so and the opportunity to practice these skills.

Driving after drinking is the most serious public health problem for teenagers. Teenagers continue to be involved in a disproportionate share of alcohol-involved fatal crashes, despite a variety of legislative, educational, and enforcement activities. One State has responded to this problem by enacting novel legislation that suspends the driving license of a person under age 20 for a year if the driver's blood alcohol level is .02 or above (by comparison, the great majority of jurisdictions impose sanctions against drivers with a blood alcohol level of .10 and above). This new State legislation is the first legislative attempt to deter all teenage drivers from driving after any drinking and to ensure sanctions for those who are apprehended. Other States are already considering similar legislation. The NIAAA is currently supporting a study to assess the effects of this new State law on teenage drinking, frequency of driving after drinking, and crash involvement. The results of studying the effects of this new approach will contribute to the growing knowledge base necessary for effective decisionmaking by public officials.

In other studies related to the prevention of drunk driving, investigators are evaluating the effectiveness of server intervention programs. One such study is evaluating a comprehensive, fully operational program on a major naval base. There is a nationwide move toward establishing the liability of commercial servers, and in some cases social servers, for the damage caused by an intoxicated patron or guest. The growing corporate and business concern over legal liability, coupled with extensive public attention to drunk driving issues, has led to increasing acceptance of server intervention programs. These programs train servers regarding responsible serving practices and also work with management to develop policies that support those practices. Additional research is needed to test and further refine the training packages, and study the cost benefits of such training.

Intramural Research

In 1987, continued growth of the scientific efforts of the intramural staff will be ensured by two additions to the intramural research program's facilities at the National Institutes of Health Clinical Center. The acquisition of permanent outpatient facilities will allow efficient management of clinical protocols that deal with family studies of the genetics of alcoholism, studies of pharmacological methods to reduce excessive alcohol intake, and studies of the pathological conditions resulting from chronic ingestion of large quantities of alcohol. The scheduled completion of the NIH centralized nuclear magnetic resonance (NMR) facility will allow NIAAA studies of neuronal membrane biophysics and the spectral characteristics of alcohol's effects on energy metabolism in brain, heart, and liver. Such studies can help clarify the molecular basis of alcohol's effects on the organs of the body, identify the initiators of alcohol-induced pathology, and lead to new methods of preventing or treating that pathology.

The intramural research program's focus on the examination of genetically determined variables that contribute to the development of alcoholism stems from a number of studies documenting a familial basis for alcoholism. Since environmental variables may also be critically involved, the work is designed to identify not only biological but also environmental factors that are hallmarks or predictors of alcoholism. The Unit of Family Studies has recruited more than 80 families in which alcoholism has occurred over several generations for a study of the physiological and behavioral characteristics of the adult alcoholics and their children. Nonalcoholic family members are also being studied. Techniques of molecular genetics, electrophysiology, endocrinology, psychology, and sociology are being applied in these studies. The studies are longitudinal and are designed to identify not only the factors that may predispose the development of alcoholism but also those that may protect individuals from becoming alcoholic.

One of the factors that may protect against the development of alcoholism is an individual's constellation of enzymes for the metabolism of alcohol. It has been hypothesized that individuals with a particular enzyme profile that leads to higher levels of acetaldehyde when alcohol is consumed may be unlikely to become alcoholic, because acetaldehyde is highly toxic and produces unpleasant symptoms. Intramural researchers are therefore investigating the genetics of alcohol metabolizing enzymes, using a variety of sophisticated techniques to determine whether particular genetic variations in their structure and function are associated with susceptibility or resistance to alcoholism.

The chronic intake of large quantities of alcohol leads not only to dependence on alcohol but also to a number of organ pathologies, not the least of which is alcohol-induced organic brain damage. Brain dysfunction has been estimated to be present in 60-70 percent of alcoholics, and organic brain syndrome associated with alcoholism is second only to Alzheimer's disease as a cause of adult dementia. Current estimates of the prevalence of alcohol-induced organic brain syndrome may actually be low due to frequent misdiagnosis, as suggested by postmortem neuropathological findings. Intramural researchers are attempting to develop methods for unambiguous early identification of alcohol-induced brain damage so remedial efforts can be instituted. In addition to extensive electrophysiological analysis, two brain imaging technologies -- positron emission tomography (PET) and nuclear magnetic resonance (NMR) -- have been brought to the analysis of brain structure and function in alcoholics and heavy consumers of alcohol.

The PET technique offers important research and clinical possibilities by allowing precise measurement and localization of certain aspects of cerebral metabolic activity. PET studies have been largely focused on measurements of localized glucose metabolism since glucose is the brain's primary energy source. This new technology has allowed intramural investigators to demonstrate decreased rates of glucose metabolism in localized brain areas in alcoholics with organic brain damage. Further investigations will ascertain the constancy of these findings and assess whether PET technology could become a diagnostic tool to distinguish alcohol-induced brain damage from other neuropathologies such as Alzheimer's disease. Such differentiations will have important prognostic and treatment implications. This search for diagnostic tools is being supplemented with assessments of treatments for alcohol-induced brain damage.

In addition to using PET technology for clinical studies, intramural researchers are evaluating the neurochemical processes that depend on glucose metabolism as a source of energy. These assessments of brain metabolism by PET are supplemented by careful studies of anatomic lesions by both computerized axial tomography and nuclear magnetic resonance imaging. Comparisons of PET and NMR data will provide a solid foundation for drawing conclusions about the character of metabolic and anatomic anomalies produced by alcohol.

The intramural research program's NMR studies will be expanded with the development of the centralized NMR facility on the NIH campus. NMR currently allows for noninvasive assessment of physiology and anatomy of a number of tissues, not just the brain. NMR spectroscopy can provide information about tissue (cellular) metabolism and can allow measurement of critical cellular constituents. NMR imaging can allow visualization of anatomy with clarity that often exceeds that of computerized tomography (CT) and without the use of ionizing radiation.

Alcohol ingestion has been shown to significantly alter the metabolism of the liver and the heart, as well as the brain. Pathological lesions of these organs have been observed in individuals who have abused alcohol for prolonged periods and in infants born to mothers who have ingested large quantities of alcohol during pregnancy. However, the mechanisms by which alcohol produces pathology in adults or infants are poorly defined. Even though cirrhosis is the ninth leading cause of death in the United States, and fatty liver is observed in nearly all heavy drinkers, the events leading to alcoholic hepatitis and liver cirrhosis are poorly understood. In addition, approximately 1 to 2 percent of the chronic abusers of alcohol develop overt signs of cardiac dysfunction and even more display depressed cardiac function when the cardiovascular system is stressed. Even before myopathy is noted, atrial dysrhythmias (atrial flutter and fibrillation) can follow binge drinking. The mechanisms and the predisposing factors for these events are still unclear. In vivo NMR spectroscopy can be used to measure intermediary energy metabolism in tissues such as liver and heart without the need to administer radioisotopes. The advantage of directly examining metabolism of various tissues by NMR spectroscopy, rather than looking for anatomical lesions, is that physiological or alcohol-induced changes affecting the heart, liver, and brain are detectable virtually immediately and can precede anatomical changes by days, weeks, or months. NMR spectroscopy is therefore better suited for early diagnosis of damage, for clarifying the mechanism by which damage occurs, and for monitoring therapeutic responses.

NMR spectra showing the relative concentrations of high energy phosphate metabolites, and thus the physiological status of heart, have recently been recorded from humans. The intramural research program has embarked on NMR studies of heart function, and will also be expanding its studies to examine liver metabolism by NMR techniques. Future expansion of the program will also allow studies of infants or young children born to mothers who consumed sizable quantities of ethanol during pregnancy. Brain development, areas of damage, and reversibility of the intrauterine effects of alcohol could be examined by NMR spectroscopy and imaging.

By allotting resources to the development of an NMR program and by promoting the training of researchers in this area of technology, the NIAAA hopes to place itself on the cutting edge of development of alcoholism-related diagnostic and research capabilities.

Another important area in which high resolution NMR spectroscopy will bring significant benefits is research on the molecular mechanisms by which alcohol produces intoxication, tolerance, and dependence. Alcohol perturbs brain function in a manner quite different from other abused drugs. It does not react with specific alcohol receptors, but instead seems to perturb the neuronal membranes in which many of the neurotransmitter receptors reside.

It has been proposed that changes in membrane chemistry are important in the development of alcohol tolerance and physical dependence. NMR techniques allow the effects of alcohol on neuronal and other cell membranes to be examined and thus have the potential to provide a theoretically sound test of the hypothesis that alcohol intoxication, tolerance, and physical dependence are determined by alcohol's perturbing effects on cell membranes. Such studies have been initiated by the intramural research program, and preliminary results indicate that chronic alcohol administration alters the physical-chemical properties of brain membranes. Additional studies have also indicated that not all membrane environments are affected equally by alcohol, and certain neurotransmitter receptor systems are particularly sensitive to alcohol's actions. For example, researchers have noted that certain cholinergic receptors that control cellular calcium metabolism may be significantly altered by chronic alcohol ingestion. This change in receptor function would be reflected by significant alterations in the transduction of signals between neurons. The changes in neuronal function could in turn be the determinants of the symptoms of alcohol withdrawal occurring in physically dependent individuals. The intramural program's continued research in this area will increase our understanding of the determinants of alcohol physical dependence and may lead to new withdrawal therapies that do not involve the currently popular substitution of other dependence-producing drugs for alcohol.

The NIAAA's intramural research program will continue in 1987 to emphasize the clarification of major issues regarding the mechanisms by which alcohol produces addiction and organ damage, the generation of novel and useful methods for diagnosing alcoholism and alcohol-induced organ damage, and the development of treatment and prevention strategies to reduce substantially the damage that alcohol produces in individuals and in society.

The request for intramural research reflects a net increase of $1,306,000. Changes in funding are itemized below:

Mandatory Increases:	
Within grade increases	+$85,000
Increased NIH Management Funds costs	+972,000
Increased NIH Service and Supply Fund costs	+33,000
Increased Standard Level User Charges	+93,000
Annualization of Clinical Services	+191,000
Increased Social Security benefits	+10,000
Increased cost of non-salary items	+77,000
Subtotal, Mandatory Increases	+1,461,000
Program Decreases:	
Reduction of equipment purchases	-155,000
Subtotal, Program Decreases	-155,000
Net Change	+1,306,000

b. Training
(Public Health Service Act, Section 472)

1987 Authorization: $260,000,000 which is shared with NIH

Budget Authority:

	1986 Appropriation	1986 Available after Sequestering	1986 Revised Estimate	1987 Estimate	Increase or Decrease
Training	$1,500,000	$1,436,000	$1,436,000	$1,327,000	-$109,000

Purpose and Method of Operation

The purpose of the Institute's programs in support of training is to ensure an adequate supply of well-trained alcohol researchers. Training support is provided through individual fellowships and grants to training institutions. The Institute supports both predoctoral and postdoctoral training but places emphasis on postdoctoral training as the most cost-efficient way to meet the needs in the alcohol research field. Support is also provided to ADAMHA's Minority Access to Research Careers (MARC) Program. The goal of the MARC Program is to strengthen minority participation in research through grants supporting honors undergraduate programs and fellowships awarded to faculty of predominantly minority institutions.

Research on the causes and the effects of alcoholism and alcohol abuse, and on the diagnosis, treatment, and prevention of alcoholism and alcohol-related problems, requires the special expertise of a wide range of scientific disciplines. Thus the training program must encompass a wide range of research areas in both the biomedical and behavioral sciences. It is particularly important to bring interdisciplinary studies and new research instrumentation to bear on the problems of alcohol abuse. Accordingly, the Institute places high priority on advanced training for individuals whose qualifications hold promise for this kind of research.

Funding levels for research training programs are as follows:

	1985 Actual		1986 Available after Sequestering		1986 Revised Estimate		1987 Estimate	
	No.	Amount	No.	Amount	No.	Amount	No.	Amount
Research Training								
Grants:								
Noncompeting........	4	$645,000	9	$1,171,000	9	$1,171,000	7	$1,027,000
Competing............	3	373,000	—	—	—	—	1	52,000
New................	2	233,000	1	50,000	1	50,000	1	47,000
Subtotal..........	9	1,251,000	10	1,221,000	10	1,221,000	9	1,126,000

	1985 Actual		1986 Available after Sequestering		1986 Revised Estimate		1987 Estimate	
	No.	Amount	No.	Amount	No.	Amount	No.	Amount
Fellowships:								
Predoctoral:								
Noncompeting.......	2	$38,000	1	$10,000	1	$10,000	—	—
New................	—	—	—	—	—	—	—	—
Supplemental.......	(1)	1,000	—	—	—	—	—	—
Subtotal..........	2	39,000	1	10,000	1	10,000	—	—
Postdoctoral:								
Noncompeting.......	5	126,000	5	130,000	5	130,000	6	$138,000
New................	3	77,000	4	75,000	4	75,000	3	63,000
Supplemental.......	(1)	7,000	—	—	—	—	—	—
Subtotal..........	8	210,000	9	205,000	9	205,000	9	201,000
Subtotal, Fellowships.........	10	249,000	10	215,000	10	215,000	9	201,000
Total, Research Training............	19	1,500,000	20	1,436,000	20	1,436,000	18	1,327,000

The number of individuals supported by the training program is as follows:

	1985 Actual	1986 Available after Sequestering	1986 Revised Estimate	1987 Estimate
Institutional Awards:				
Predoctoral	23	19	19	20
Postdoctoral	36	37	37	34
Subtotal	59	56	56	54
Fellowships:				
Predoctoral	2	1	1	---
Postdoctoral	8	9	9	9
Subtotal	10	10	10	9
Totals:				
Predoctoral	25	20	20	20
Postdoctoral	44	46	46	43
Total	69	66	66	63

Rationale for the Budget Request

The 1987 estimate will allow the NIAAA to continue, at a reduced level, the current program of predoctoral and postdoctoral training in alcohol research. Training will be provided for 63 trainees, a reduction of 5 percent from the 1986 level. The level of support per trainee, for both stipend and nonstipend support, will be maintained at the 1986 level.

BEST COPY AVAILABLE

Continuing efforts include support for research training in the basic biological and behavioral processes relevant to investigations of the causes and effects of alcoholism, as well as epidemiological and clinical research training. Within the limited number of new training slots available, special emphasis will be placed on advanced training for geneticists, molecular biologists, and neuroscientists, which are areas with enormous potential for future progress in alcohol research.

c. Direct Operations
(Public Health Service Act, Section 301)

1987 Authorization: Indefinite

Budget Authority:

	1986 Appropriation	1986 Available after Sequestering	1986 Revised Estimate	1987 Estimate	Increase or Decrease
Direct Operations	$11,658,000	$11,157,000	$11,157,000	$10,876,000	-$281,000
FTEs			110	110	---

Purpose and Method of Operations

The Institute's direct operations activities provide overall management of the extramural research and research training programs, prevention efforts, and research dissemination activities. Salaries and other support costs are provided for the staff who give scientific direction as well as technical and administrative support in the development and implementation of the Institute's programs. The staff provides management of the grant review and award process and monitors the progress of research grants, contracts, and training projects.

Staff expertise is augmented by outside experts who assist the Institute in identifying scientific opportunities, setting priorities, and fostering the timely application of new research knowledge. Over the past year, the Institute has coordinated several conferences and workshops in areas of special interest to researchers, clinicians, and prevention personnel in the field. One of these was focused on alcohol problems of the homeless, with the goal of developing a research agenda in this area and generating innovative ideas that may lead to better prevention, intervention, and treatment services for this population. A review of the research on the homeless indicates that 20 to 45 percent have alcohol-related problems, compared to 7 percent of the general population. The Institute also convened a meeting of experts to review current knowledge of the effects of alcohol on the immune system and the connection between alcohol use and acquired immune deficiency syndrome (AIDS). The experts provided advice on the research that is needed to clarify the role of alcohol in immune suppression and on the information needs of the public and the health professions on the relationship of alcohol consumption and AIDS. These efforts are expected to stimulate additional high-quality applications for research relevant to alcohol problems among the homeless and to the effects of alcohol on the immune system.

The Institute's prevention efforts include a public education campaign to assist youth in developing attitudes and skills necessary to prevent them from developing alcohol problems. Other prevention efforts, as well as research dissemination activities, are carried out by the National Clearinghouse for Alcohol Information in partnership with various private-sector organizations interested in preventing alcohol abuse.

The Institute is also working with concerned groups to find ways to upgrade the alcohol-related knowledge and skills of clinicians. In collaboration with the Association for Medical Education and Research in Substance Abuse and the National Institute on Drug Abuse, the NIAAA recently held a conference on the minimal knowledge and skills required by primary care physicians in order to deal with their patients' alcohol and drug problems. The final report, which includes information on how the goal of improved skills can be achieved, is being widely disseminated to organizations with interest and responsibilities in this important area.

Rationale for Budget Request

The 1987 estimate reflects a net reduction of $281,000 from the 1986 funding level. The reduction will be accomplished through several cost saving measures, including a reduction for administrative overhead and a program reduction in contract funding.

Changes in funding are itemized below:

Mandatory Increases:	
Within grade increases	+$99,000
Increased FTS costs	+5,000
Increased payments to Federal Employee Compensation Fund	+5,000
Increased Social Security benefits	+12,000
Increased cost of non-salary items	+227,000
Subtotal, Mandatory Increases	+348,000
Mandatory Decreases:	
Reduction for Service and Supply Fund	-14,000
Reduction for Standard Level User Charges	-27,000
Subtotal, Mandatory Decreases	-41,000
Program Decreases:	
Reduction for administrative overhead	-195,000
Reduction of contract costs	-393,000
Subtotal, Program Decreases	-588,000
Net Change	-281,000

IV. Buildings and Facilities
(Section 301 of the Public Health Service Act)

1987 Authorization - Indefinite

Budget Authority:

	1986 Appropriation	1986 Available after Sequestering	1987 Request	Increase/ Decrease
	$100,000	$96,000	$600,000	+$500,000
Oblig.....	(1,320,000)	(1,316,000)	(600,000)	(-716,000)

Purpose and Method of Operations - This activity provides funds to assure that facilities for ADAMHA intramural research activities housed in government-owned and leased buildings are adequate and properly maintained. Funds are provided to support necessary design studies, construction, renovations and major equipment purchases and repair, primarily through the contract mechanism. No major construction activities were undertaken in 1986.

Rationale for Budget Request - The 1987 request provides for essential repairs and improvements to ADAMHA intramural research facilities. Of the requested amount, $200,000 is for general repairs and improvements to ADAMHA intramural facilities which include the William A. White Building, located at SEH; NIAAA research facility; Baltimore City Hospital; and for programs on the NIH campus.

The remaining $400,000 is essential for vital repairs and improvements at the NIAAA research facility. The repairs and improvements include alterations to the heating and ventilation system in the animal rooms in order to be in compliance with Federal standards governing the care and housing of animals used in research. The second vital improvement is for renovation to the NIAAA research facility to accommodate genetic research which is to be started in 1986. Molecular genetic research requires that Federal safety measures be installed in order to ensure the safety of the research staff.

V. Program Management
(Public Health Service Act, Section 301)

1987 Authorization: Indefinite

Budget Authority:

	1986 Appropriation	1986 Available after Sequestering	1987 Estimate	Increase/ Decrease
Prog. Mgmt...	$7,620,000	$7,292,000	$7,390,000	+$98,000
FTEs.......			149	---

Purpose and Method of Operation - The Office of the Administrator is responsible for providing policy guidance, coordination and general support services to the three ADAMHA Institutes. It maintains a strong role in the management and oversight of all agency activities, and provides a focus for addressing new national responsibilities in the areas of alcoholism, drug abuse, and mental health.

In 1986 the Office of the Administrator (OA) continued to provide centralized services relating to personnel, financial management, grants management, equal employment opportunity and the award of ADAMHA block grants to the States. The OA program staff was directly involved with the block grant program through reviewing applications, reviewing and resolving complaints, conducting compliance reviews, and providing technical assistance. The OA also maintained a leadership role in agency planning and policy matters.

In 1986 the OA expanded policy coordination activities, particularly in the areas of science and prevention. Special activities conducted included planning and coordinating prevention programs and assessing approaches to support research, including stabilization policy and support mechanisms. Also, continued coordination was provided for both a facilities and fiscal audit of Saint Elizabeths Hospital in preparation for transfer to the District of Columbia in 1988.

Rationale for the Budget Request - The 1987 estimate for the Office of the Administrator provides mandatory increases of $178,000 to support and maintain the essential leadership, policy and administrative functions performed by the office. The estimate also provides mandatory decreases of $39,000 for the Service and Supply Fund and the Standard Level User Charge (SLUC) and a program reduction of $41,000 which will be achieved by reducing program-related conferences and contracts, equipment purchases, as well as staff travel and training.

The request for program management reflects a net increase of $98,000. Changes in funding are itemized below:

Mandatory Increases:	
Within grade increases	+$130,000
Increased FTS costs	+3,000
Increased cost of Social Security Benefits	+16,000
Increased cost of non-salary items	+29,000
Subtotal, Mandatory Increases	+178,000
Mandatory Decreases:	
Decreased costs of Service and Supply Fund	-7,000
SLUC reduction	-32,000
Subtotal, Mandatory Decreases	-39,000
Program Decreases:	
Other administrative reductions	-41,000
Subtotal, Program Decreases	-41,000
Total, Net Change	+$98,000

VI. ADAMHA Block Grant
(Title XIX of the Public Health Service Act)

1987 Authorization........ $576,000,000

Budget Authority:

	1986 Appropriation	1986 Available after Sequestering	1987	Increase or Decrease
Block Grants...........	$490,000,000	$468,930,000	$490,000,000	+$21,070,000
Program Management.....	(1,028,000)	(983,796)	(1,028,000)	(+44,204)

Purpose and Method of Operation - The major purpose of the ADAMHA block grant program is to provide funds to the States in support of their alcohol, drug abuse and mental health prevention, treatment and rehabilitation services. This funding mechanism, which was initiated in 1982, replaced the categorical services program supported by the agency for 20 years. The block grants provide the States the flexibility to plan, implement and control their own health services in order to best meet their specific needs.

The agency's responsibility for the block grant includes review and approval of grant applications, reviewing and resolving complaints, conducting and reporting on compliance reviews, and determining the amount of individual State awards.

Since 1982, States have utilized block grants to fund programs that support:

1. the maintenance of community mental health centers;
2. both inpatient and outpatient alcohol and drug detoxification programs and counseling;
3. dissemination of public awareness efforts related to troubled youths and availability of mental health services though articles in educational or mental health publications;
4. alcohol and drug abuse prevention programming including school presentations, classes on responsible decision-making and training programs for teachers;
5. community day treatment programs and residential programs for the chronically mentally ill;
6. community outreach and intervention programs designed for early identification and entry into treatment; and
7. community outpatient treatment programs for families and youth, experiencing difficulties due to alcoholism or drugs;

Rationale for 1987 Request - The 1987 request will provide an increase of $21,070,000 over the 1986 estimate and restore block grant support to the 1985 level.

State Block Grants

States	1985	1986	1987
Total	$490,000,000	$468,930,000 1/	$490,000,000 2/
Alabama......................	$9,328,000	$9,328,000	$9,328,000
Alaska........................	2,093,000	2,093,000	2,093,000
Arizona......................	9,004,000	9,004,000	9,004,000
Arkansas.....................	6,385,000	6,385,000	6,385,000
California...................	48,406,000	45,044,000	48,822,000
Colorado.....................	7,004,000	7,004,000	7,004,000
Connecticut..................	6,985,000	6,985,000	6,985,000
Delaware.....................	1,428,000	1,428,000	1,428,000
District of Columbia........	2,467,000	2,467,000	2,467,000
Florida......................	24,033,000	24,033,000	24,033,000
Georgia......................	11,093,000	10,077,000	11,048,000
Hawaii.......................	2,827,000	2,827,000	2,827,000
Idaho.....	1,660,000	1,481,000	1,656,000
Illinois.....................	19,574,000	17,749,000	19,489,000
Indiana......................	19,524,000	19,524,000	19,524,000
Iowa.........................	2,936,000	2,446,000	2,916,000
Kansas.......................	3,962,000	3,574,000	3,947,000
Kentucky.....................	4,551,000	3,868,000	4,517,000
Louisiana....................	5,565,000	4,894,000	5,640,000
Maine........................	3,733,000	3,733,000	3,733,000
Maryland.....................	4,871,000	4,195,000	4,842,000
Massachusetts................	18,240,000	18,240,000	18,240,000
Michigan.....................	15,948,000	14,434,000	15,870,000
Minnesota....................	4,933,000	4,255,000	4,898,000
Mississippi..................	5,165,000	4,643,000	5,137,000
Missouri.....................	9,504,000	8,955,000	9,761,000
Montana......................	2,153,000	2,153,000	2,153,000
Nebraska.....................	2,683,000	2,417,000	2,673,000
Nevada.......................	2,897,000	2,897,000	2,897,000
New Hampshire................	3,844,000	3,844,000	3,844,000
New Jersey...................	20,647,000	20,647,000	20,647,000
New Mexico...................	4,934,000	4,934,000	4,934,000
New York.....................	40,097,000	40,097,000	40,097,000
North Carolina...............	10,963,000	9,856,000	10,914,000
North Dakota.................	1,163,000	1,052,000	1,160,000
Ohio.........................	23,585,000	23,585,000	23,585,000
Oklahoma.....................	7,775,000	7,775,000	7,775,000
Oregon.......................	5,670,000	5,503,000	5,941,000
Pennsylvania.................	25,114,000	25,114,000	25,114,000
Rhode Island.................	4,417,000	4,417,000	4,417,000

State Block Grants

States	1985	1986	1987
Total	$490,000,000	$468,930,000 1/	$490,000,000 2/
S. Carolina	$6,684,000	$6,070,000	$6,657,000
S. Dakota	3,100,000	3,100,000	3,100,000
Tennessee	7,798,000	6,937,000	7,759,000
Texas	21,446,000	18,885,000	21,381,000
Utah	3,778,000	3,525,000	3,822,000
Vermont	3,313,000	3,313,000	3,313,000
Virginia	8,384,000	7,479,000	8,348,000
Washington	8,977,000	8,977,000	8,977,000
West Virginia	4,292,000	3,926,000	4,272,000
Wisconsin	5,263,000	4,467,000	5,225,000
Wyoming	768,000	687,000	766,000
American Samoa	16,000	11,000	16,000
Guam	536,000	536,000	536,000
Northern Mariana Islands	32,000	29,000	32,000
Puerto Rico	6,875,000	6,875,000	6,875,000
Trust Territories	64,000	43,000	63,000
Virgin Islands	1,113,000	1,113,000	1,113,000

1/ Reflects a reduction of $21,070,000 pursuant to the Balanced Budget and Emergency Deficit Control Act of 1985, P.L. 99-177.

2/ Allocations are subject to revision based upon updated population and per capita income data.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

Detail of Permanent Positions

	1985 Act.	1986 Est.	1987 Est.
ES-5	5	5	5
ES-4	24	25	25
ES-3	2	3	4
ES-2	4	2	1
ES-1	0	0	0
Subtotal	35	35	35
GS-15	118	113	113
GS-14	130	125	125
GS-13	116	111	111
GS-12	83	80	80
GS-11	86	83	83
GS-10	2	2	2
GS-09	92	88	88
GS-08	34	33	33
GS-07	122	117	117
GS-06	65	62	62
GS-05	24	23	23
GS-04	9	9	9
GS-03	1	1	1
GS-02	0	0	0
GS-01	0	0	0
Subtotal	882	847	847
Grades Established by the Public Health Service Act of 1955 (42.U.S.C. 207)			
CC-08/09 (50,299 to 77,695)	2	2	2
CC-07 (41,796 to 50,905)	0	0	0
CC-06 (24,775 to 43,661)	33	32	32
CC-05 (30,978 to 53,514)	55	53	53
CC-04 (20,884 to 36,511)	14	13	13
CC-03 (19,408 to 31,576)	2	2	2
CC-02 (16,924 to 23,432)	0	0	0
CC-01 (14,692 to 18,482)	0	0	0
Subtotal	106	102	102
Ungraded	21	20	20
TOTAL FULL TIME PERM POSITIONS	1,044	1,004	1,004
UNFILLED POSITIONS,EOY	0	0	0
TOTAL FULL TIME PERM EMPLOYMENT,EOY	1,044	1,004	1,004

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
Estimates for Consulting Services

Account Title	Type 1/	Source of Funds 2/	Obligations 1985	1986 Appropriation	1986 Revised	1987
Evaluation:						
Alcohol, Drug Abuse, and Mental Health.........	C	A	$1,079,000	$1,540,000	$890,000	$568,000
Alcohol, Drug Abuse, and Mental Health.........	C	N	---	---	---	---
Alcohol, Drug Abuse, and Mental Health.........	P	A	---	---	---	---
Alcohol, Drug Abuse, and Mental Health.........	P	N	---	---	---	---
Alcohol, Drug Abuse, and Mental Health.........	A	A	---	---	---	---
Alcohol, Drug Abuse, and Mental Health.........	A	N	---	---	---	---
Subtotal, evaluation...............			1,079,000	1,540,000	890,000	568,000
Nonevaluation:						
Alcohol, Drug Abuse, and Mental Health.........	C	A	1,030,000	1,460,000	1,460,000	1,149,000
Alcohol, Drug Abuse, and Mental Health.........	C	N	250,000	---	---	---
Alcohol, Drug Abuse, and Mental Health.........	P	A	21,000	48,000	48,000	51,000
Alcohol, Drug Abuse, and Mental Health.........	P	N	89,000	---	---	---
Alcohol, Drug Abuse, and Mental Health.........	A	A	39,000	75,000	75,000	83,000
Alcohol, Drug Abuse, and Mental Health.........	A	N	---	---	---	---
Subtotal, nonevaluation............			1,429,000	1,583,000	1,583,000	1,283,000
Total, consulting services.........			$2,508,000	$3,123,000	$2,473,000	$1,851,000
TOTALS:						
Contractual Services................			$2,359,000	$3,000,000	$2,350,000	$1,717,000
Personnel Appointments..............			110,000	48,000	48,000	51,000
Advisory committee expenses........			39,000	75,000	75,000	83,000
Total, consulting services.........			$2,508,000	$3,123,000	$2,473,000	$1,851,000

1/ C represents contractual services, P personnel appointments and A advisory committee obligations.

2/ A indicates appropriated funds and N non-appropriated funds.

Narrative

Evaluation:

Evaluation contracts are used to assess ongoing agency programs in the extramural research, research training, and technical assistance areas when in-house staff are not available for this purpose. Evaluations will be supported in the areas of prevention, national statistics reporting programs, and several of the program areas supported by the agency. These evaluations contribute formal objective information which is considered in management policy decisions and resource allocations. This valuable management tool contributes significantly to program efficiency and effectiveness, and cannot be utilized other than through this mechanism.

Non-evaluation:

General consultant contracts and purchase orders are utilized primarily to evaluate and analyze research findings, other than that accomplished directly by researchers, to provide advice and assistance to agency management, and to develop prevention materials. These mechanisms also enable staff to assist States and local governments in areas related to the provision of services and training. Experts are asked to provide administrative support for planning and managing specific research and development projects; for example, data collection and analysis is supported in order to make data more available, more accessible, and less costly to collect than if done by the government.

Appointive consultants are utilized in both the extramural and intramural research areas, as well as for technical assistance. In the research areas, consultants are asked to provide advice which will augment our knowledge of the state of the art or on specific research problems. These services are essential for research planning, elimination of duplication of research efforts, and to provide solutions to problems which can delay or adulterate research activities. In the technical assistance area, these activities enable the agency to assist in, and replicate successful, cost-effective research and demonstration programs.

Advisory committees, established by legislation, provide guidance on research grant funding decisions and make recommendations on agency program directions in the research area. These include the national advisory councils and the initial review groups. They are integral parts of the peer review process, ensuring the quality of research.

The peer review process ensures that a knowledgeable and objective review is applied to all grant applications before funding decisions are proposed by advisory councils and carried out by agency staff. Experts in the professions, disciplines, and fields of activity of the applicants are utilized to provide advice solely on the scientific and technical merit of grant applications. Most reviewers are appointed as consultants and provide their services through the chairman's award mechanism. Ad hoc review groups are occasionally brought together, however, to review applications requiring expertise not available on a standing committee; applications where there is the potential for a conflict of interest with regular appointed reviewers; or applications submitted in response to special initiatives where there currently is no chartered review committee. This process is the foundation for ensuring excellence in the agency's grant programs and enhances the achievement of the public objective for which grant funds are appropriated.

The amount requested in 1987 will allow for continuation of these essential activities at a reduced level.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH

Estimates for Related Services

Account Title	Type 1/	Source of Funds 2/	Obligations 1985	1986 Appropriation	1986 Revised	1987
Alcohol, Drug Abuse, and Mental Health.........	MP	A	$3,126,000	$4,564,000	$3,158,000	$711,000
Alcohol, Drug Abuse, and Mental Health.........	MP	N	422,000	---	---	---
Alcohol, Drug Abuse, and Mental Health.........	SA	A	780,000	746,000	608,000	132,000
Alcohol, Drug Abuse, and Mental Health.........	SA	N	---	---	---	---
Alcohol, Drug Abuse, and Mental Health.........	RD	A	762,000	1,494,000	1,230,000	2,045,000
Alcohol, Drug Abuse, and Mental Health.........	RD	N	---	---	---	---
Total, related services............			$5,090,000	$6,804,000	$4,996,000	$2,888,000
TOTALS:						
Management and professional services			$3,548,000	$4,564,000	3,158,000	$711,000
Special studies and analyses........			780,000	746,000	608,000	132,000
Management and support services for research and development activities			762,000	1,494,000	1,230,000	2,045,000
Total, related services............			$5,090,000	$6,804,000	4,996,000	$2,888,000

1/ Indicate MP for management and professional services, SA for special studies and analyses, or RD for management and support services for research and development activities.

2/ Indicate A for appropriated funds or N for non-appropriated funds.

Narrative

The Alcohol, Drug Abuse, and Mental Health Administration supports activities through the contract mechanism which include the development of public education campaign materials for dissemination by the States; dissemination of research findings; conferences to examine research, prevention and treatment issues; and support of specific research activities which cannot be addressed through any other mechanism. Activities of this type are essential to time and cost-efficient program administration.

The 1987 request includes continued support in areas such as the Epidemiology, Planning, Research Analysis and Utilization System and the State Voluntary Collection effort. The amount requested in 1987 will allow for continuation of these activities, as well as a limited number of other on-going projects, at a reduced rate from the 1986 level.

The revised 1986 column excludes $1,175,000 which is for the comparable transfer of Priority Disease Control and Research Projects (AIDS) to the Office of the Assistant Secretary for Health.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION
Saint Elizabeths Hospital

FY 1987 Budget — Page

Appropriation language 144

Amounts available for obligation 145

Summary of changes 146

Obligations by activity 147

Obligations by object 148

Authorizing legislation 149

Table of estimates and appropriations...................... 150

Account Summary: 151

A. General statement 152

B. Program accomplishments................................. 153

C. Activity:

(1) Inpatient psychiatric care...................... 154
(2) Inpatient custodial care pending court ordered outplacement.................. 155
(3) Area D Community Mental Health Center (CMHC) outpatients.................. 156
(4) Outpatient, day care, and outplacement activities other than Area D (CMHC)............ 157
(5) Research.. 158
(6) Training.. 159
(7) Program support................................. 160

D. Estimates for consulting services...................... 161

E. Detail of permanent positions.......................... 163

F. Supplementary data:

(1) Patient load.................................... 165
(2) Reimbursement detail............................ 166

Federal Subsidy for Saint Elizabeths Hospital

For a portion of the cost of the maintenance and operation of Saint Elizabeths Hospital in the District of Columbia [$43,696,000] *$36,25[illegible]*: Provided, That in fiscal year [1986] *1987 and thereafter* the maximum amount available to Saint Elizabeths Hospital from Federal sources shall not exceed the total of the following amounts: the appropriations made under this heading, amounts billed to Federal agencies and entities by the Secretary of Health and Human Services for services provided at Saint Elizabeths Hospital, and amounts authorized by Titles XVIII and XIX of the Social Security Act: *Provided further*, That this amount shall not include Federal funds appropriated to the District of Columbia under "Federal Payment to the District of Columbia" and payments made pursuant to section 9(c) of Public Law 98-621: *Provided further*, That the Secretary of Health and Human Services may set rates which in the aggregate do not exceed the estimated total cost of inpatient and outpatient services provided through Saint Elizabeths Hospital as authorized by title 16, section 2315 and 2320, title 21, sections 511, 513, 522, 545, 902, and 1116 and title 24, sections 301 and 302 of the District of Columbia Code, and may bill and collect from (prospectively or otherwise) individuals, the District of Columbia and other entities for any service provided: *Provided further*, That the Secretary of Health and Human Services may set rates which in the aggregate do not exceed the estimated total cost of inpatient and outpatient services provided through Saint Elizabeths Hospital as authorized by title 24, sections 191, 196, 211, 212, 222, 253, and 324, title 31, section 1535, and title 42, sections 249 and 251 of the United States Code, and may bill and collect (prospectively or otherwise) from individuals, Federal agencies, and other entities for any services so provided. Amounts so collected shall be credited to the appropriation for Saint Elizabeths Hospital and shall remain available until expended. (Department of Health and Human Services Appropriation Act, 1986).

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION
Saint Elizabeths Hospital

Amounts Available for Obligation

	1985	1986	1987
Appropriation:			
Annual........................	$48,595,000	$43,696,000	$36,353,000
Sequester order..............	---	-1,879,000	---
Subtotal, adjusted appropriation............	48,595,000	41,817,000	36,353,000
Receipts and reimbursements from:			
Federal funds................	16,509,000	18,165,000	17,971,000
Trust funds..................	3,354,000	3,235,000	3,241,000
Non-federal sources..........	58,720,000	67,827,000	79,189,000
Reduction in new spending authority....................		-1,842,000	
Unobligated balance lapsing.....................	---	-78,000[1/]	---
Total obligations............	127,178,000	129,124,000	136,754,000

[1/] $78,000 withheld as required by the Treasury, Postal Service, and General Government Appropriations Act, 1986.

SUMMARY OF CHANGES

	Budget Authority	Reimbursements	Lapsed Funds	Obligations
1986 Estimate....................	$43,696,000	$89,227,000	$ ---	$132,923,000
1986 Sequester order (B.A.).....	-1,879,000	---	---	-1,879,000
Subtotal........................	41,817,000	89,227,000	---	131,044,000
1986 Sequester order (offsetting collections lapsed)....	---	---	-1,842,000	-1,842,000
1986 Unobligated balance lapsing[1]......................	---	---	-78,000	-78,000
Total estimated Budget authority	41,817,000	89,227,000	-1,920,000	129,124,000
1987 Request.....................	36,353,000	100,401,000	---	136,754,000
Net change.......................	-5,464,000	+11,174,000	+1,920,000	+7,630,000

	1986 Base		Change from Base	
	Pos. (FTE)	Amount	Pos. (FTE)	Amount
Increases:				
A. Built-in:				
1. Within-grade increases.........	---	$105,774,000	---	$+2,068,000
2. Social security payment........	---	1,850,000	---	+175,000
3. Payment to F.E.C.F.............	---	1,493,000	---	+328,000
4. Travel and transportation......	---	658,000	---	+29,000
5. Utilities......................	---	3.232,000	---	+152,000
6. Printing.......................	---	106,000	---	+4,000
7. Medical services contract......	---	3.957,000	---	+166,000
8. Maintenance and repair of medical equipment.............	---	932,000	---	+40,000
9. Outplacement contracts.........	---	1,058,000	---	+44,000
10. Other contractual services.....	---	3,871,000	---	+148,000
11. Medical supplies, including drugs.........................	---	2,293,000	---	+112,000
12. Food, bedding, and clothing....	---	3,337,000	---	+132,000
13. Other supplies.................	---	5,702,000	---	+213.000
14. Equipment......................	---	1,027,000	---	+41,000
15. NIMH research support..........	---	3,734,000	---	+157,000
Subtotal.......................	---	---	---	+3,809,000
B. Program:				
1. Audit-accrued annual leave.....	---	---	---	+100,000
2. Maintenance of current program level.........................	---	---	---	+3,721,000
Subtotal.......................	---	---	---	+3,821,000
Total increases................	---	---	---	+7,630,000
(Budget authority).............	---	---	---	(-5,464,000)

---

[1] $78,000 withheld as required by the Treasury, Postal Service, and General Government Appropriations Act, 1986.

Saint Elizabeths Hospital

Obligations by Activity

	1986 Appropriation	1986 Available After Sequestering	1986 Revised		1987	
	Amount	Amount	FTE	Amount	FTE	Amount
1. Inpatient psychiatric care................. (Budget authority).......	$67,714,000 (27,772,000)	$ 65,689,000 (26,578,000)	1,987 (761)	$ 65,689,000 (26,578,000)	--- (---)	$ 69,575,000 (23,047,000)
2. Inpatient custodial care pending court-ordered outplacement............ (Budget authority).......	8,864,000 (---)	8,648,000 (---)	210 (---)	8,648,000 (---)	--- (---)	9,021,000 (---)
3. Area D Community Mental Health Center (CMHC) outpatients...... (Budget authority).......	2,553,000 (---)	2,491,000 (---)	38 (---)	2,491,000 (---)	--- (---)	2,627,000 (---)
4. Outpatient, day care, and outplacement activities, other than Area D CMHC.. (Budget authority).......	5,861,000 (2,581,000)	5,692,000 (2,470,000)	105 (55)	5,692,000 (2,470,000)	--- (---)	6,021,000 (2,361,000)
Research................. (Budget authority).......	3,734,000 (---)	3,734,000 (---)	60 (---)	3,734,000 (---)	--- (---)	3,891,000 (---)
Training................. (Budget authority).......	2,665,000 (1,329,000)	2,586,000 (1,272,000)	72 (70)	2,586,000 (1,272,000)	--- (---)	2,742,000 (1,215,000)
7. Program support.......... (Budget authority).......	41,362,000 (12,014,000)	40,362,000 (11,497,000)	986 (206)	40,284,000 (11,497,000)	--- (---)	42,877,000 (9,730,000)
Total obligations........ (Budget authority).......	132,923,000 (43,696,000)	129,202,000 (41,817,000)	3,458 (1,092)	129,124,000 (41,817,000)	--- (---	136,754,000 (36,353,000)

Saint Elizabeths Hospital

Obligations by Object

	1986	1987	Increase or Decrease
Full-time equivalent of full-time permanent positions............	1,092[1]	---	-1,092
Full-time equivalent of all other positions................	62	---	-62
Total compensable work Years...............................	1,169	---	-1,169
Average ES salary.....................	$66,523	---	---
Average GS grade......................	GS-8	---	---
Average GS salary.....................	25,828	---	---
Average salary of ungraded positions...........................	23,880	---	---
Personnel compensation:			
Full-time Permanent.................	$78,266,000	$81,916,000	$+3,650,000
Other than full-time permanent.....	6,471,000	6,743,000	+272,000
Other personnel compensation.......	6,500,000	6,879,000	+379,000
Special personal service payment...	1,382,000	1,434,000	+52,000
Total, personnel compensation.....	92,619,000	96,972,000	+4,353,000
Personnel benefits...................	11,991,000	13,011,000	+1,020,000
Travel and transportation of persons............................	474,000	516,000	+42,000
Transportation of things............	183,000	195,000	+12,000
Rent, communications and utilities...	3,341,000	3,618,000	+277,000
Printing and reproduction............	77,000	84,000	+7,000
Other services.......................	8,907,000	9,896,000	+989,000
Supplies and materials...............	10,482,000	11,332,000	+850,000
Equipment............................	950,000	1,027,000	+77,000
Lands and structures.................	88,000	91,000	+3,000
Claims and indemnities...............	12,000	12,000	---
Total obligations by object........	$129,124,000[2]	$136,754,000	$+7,630,000
(Budget authority)...................	(41,817,000)	(36,353,000)	(-5,464,000

---

[1] Only FTEs associated with federal budget authority are reflected.

[2] Excludes $78,000 withheld as required by the Treasury, Postal Service, and General Government Appropriations Act, 1986 and reflects a reduction of $3,721,000 pursuant to the Balanced Budget and Emergency Deficit Control Act of 1985, P.L. 99-177.

Saint Elizabeths Hospital

Authorizing Legislation

	1986 Amount Authorized	Available after Sequestering	1986 Revised Estimate	1987 Amount Authorized	1987 Budget Request
Saint Elizabeths Hospital:					
Title 24, U.S.C. Chapter 4........	Indefinite	$129,202,000	$129,124,000 2/	Indefinite	$136,754,000
(Budget authority)		(41,817,000)	(41,817,000)		(36,353,000)

1/ New authorizing legislation (Public Law 98-621) has been enacted but its funding provisions do not encompass the total level of Federal support for Saint Elizabeths Hospital until the beginning of FY 1988.

2/ Excludes $78,000 withheld as required by the Treasury, Postal Service, and General Government Appropriations Act, 1986.

Saint Elizabeths Hospital

Table of Estimates and Appropriations

	Budget Estimate To Congress	House Allowance	Senate Allowance	Appropriation
1978	$74,484,000	$74,484,000	$74,484,000	$74,484,000
1979	75,824,000	75,824,000	75,824,000	79,252,000
1980	85,119,000	85,119,000	85,119,000	91,915,000
1981	94,273,000	94,273,000	94,273,000	99,401,000
1982	87,000,000	94,743,000	94,743,000	95,418,000
1983	67,505,000	76,505,000	76,505,000	75,119,000
1984	62,744,000	62,744,000	67,744,000	67,744,000
1985	48,595,000	48,595,000	48,595,000	48,595,000
1986	42,488,000	43,696,000	43,696,000	43,696,000
1986 Sequester	-1,879,000			
1987	36,353,000			

Saint Elizabeths Hospital

Account Summary

	1986 Appropriation	1986 Available After Sequestering	1986 Revised Estimate	1987	Increase or Decrease
Inpatient psychiatric care........	$67,614,000	$65,689,000	$65,689,000	$69,575,000	$+3,886,000
(Budget authority).	(27,772,000)	(26,578,000)	(26,578,000)	(23,047,000)	(-3,531,000)
(FTE/B.A.).........			(761)	(---)	(-761)
Inpatient custodial care pending court-ordered outplacement......	8,864,000	8,648,000	8,648,000	9,021,000	+373,000
(Budget authority).	(---)	(---)	(---)	(---)	(---)
(FTE/B.A.).........			(---)	(---)	(---)
Area D Community Mental Health Center (CMHC) outpatients.......	2,553,000	2,491,000	2,491,000	2,627,000	+136,000
(Budget authority).	(---)	(---)	(---)	(---)	(---)
(FTE/B.A.).........			(---)	(---)	(---)
Outpatient, day care, and outplacement activities, other than Area D CMHC..............	5,861,000	5,692,000	5,692,000	6,021,000	+329,000
(Budget authority).	(2,581,000)	(2,470,000)	(2,470,000)	(2,361,000)	(-109,000)
(FTE/B.A.).........			(55)	(---)	(-55)
5. Research...........	3,734,000	3,734,000	3,734,000	3,891,000	+157,000
(Budget authority).	(---)	(---)	(---)	(---)	(---)
(FTE/B.A.).........			(---)	(---)	(---)
6. Training...........	2,665,000	2,586,000	2,586,000	2,742,000	+156,000
(Budget authority).	(1,329,000)	(1,272,000)	(1,272,000)	(1,215,000)	(-57,000)
(FTE/B.A.).........			(70)	(---)	(-70)
7. Program support....	41,632,000	40,362,000	40,284,000	42,877,000	+2,593,000
(Budget authority).	(12,014,000)	(11,497,000)	(11,497,000)	(9,730,000)	(-1,767,000)
(FTE/B.A.).........			(206)	(---)	(-206)
Total obligations..	132,923,000	129,202,000	129,124,000	136,754,000	+7,630,000
(Budget authority).	(43,696,000)	(41,817,000)	(41,817,000)	(36,353,000)	(-5,464,000)
(FTE/B.A.).........			(1,092)	(---)	(-1,092)

General Statement

Saint Elizabeths Hospital is a 132 year old public mental health treatment facility which historically has provided acute and long-term psychiatric care to beneficiaries of Federal agencies and residents of the District of Columbia. As a public institution, the Hospital has focused its treatment mission on individuals who are severely disabled due to mental illness and who cannot afford to bear the full costs of their care in private facilities. In addition to its adult inpatient psychiatric program, the Hospital operates: (1) a security treatment facility; (2) a community mental health center which serves a District catchment area of approximately 160,000 residents; (3) a clinical training program with the trainees serving in direct clinical care roles; (4) a child and adolescent treatment program; and (5) a mental health program for the deaf. The National Institute for Mental Health (NIMH) operates a research facility on the Hospital grounds.

The Hospital's total program budget of $136,754,000 will permit continued operations at FY 1986 level. All FY 1986 programs are retained; no expansion of programs is planned. The 1987 request does include funds required to restore FY 1986 program cuts necessitated by initial application of the Balanced Budget and Emergency Deficit Control Act of 1985. Outpatient census is projected at 2,800, which is approximately the level for 1985 and 1986.

The budget request of $36,353,000 represents the fifth year of a ten-year plan for the District government's gradual assumption of financial responsibility for its residents at Saint Elizabeths Hospital. Public Law 98-621, which transfers Saint Elizabeths Hospital to the District government on October 1, 1987, affirmed the policy of phasing down the direct Federal subsidy to Saint Elizabeths Hospital. Although about 90 percent of the patients at Saint Elizabeths Hospital are District residents, the 1987 budget request assumes that the District government will pay only 56 percent of the cost of operating the Hospital. Public Law 98-621 authorized an additional subsidy to the District government for payments to Saint Elizabeths Hospital (requested under the "Federal Payment to the District of Columbia"), which further reduces the District government's payments from its own funds. The 1987 request assumes that the District government will support the full cost of primarily custodial and outpatient care provided to District residents. The Federal government will fund the full cost of National Institute of Mental Health research and care provided to individuals referred by Federal agencies.

Program Accomplishments

Fiscal year 1987 will be the last year of Federal management of Saint Elizabeths Hospital. Emphasis will be placed on assuring that the historical quality of clinical programs is maintained and that all actions necessary to achieve a smooth transfer of management to the District of Columbia Government are accomplished. In FY 1987, program objectives include the following:

- Participation in preparation of the District's final plan for a comprehensive public mental health services delivery system for District residents.

- Prudent use of existing funds for facility renovations which will ensure adequate capacity for the District of Columbia government comprehensive public mental health services delivery system.

- Continued development of patient billing and accounts receivable management initiated during FY 1986, which will help increase independent revenues in subsequent years. The Hospital will continue to generate the maximum amount of such revenues in an effort to increase the proportionate share of its operating budget derived from independent revenues rather than direct appropriation.

- Continued progress on the Dixon implementation plan by the Hospital and District government will result in a decrease in overall admissions to inpatient status, an increase in the number of outplacements of current inpatients, improvement in the availability of outpatient services from both the Hospital and the District government, and an overall reduction in inpatient average daily census at the end of the fiscal year to approximately 1,469.

Details relating to each of the hospital's seven budget activities are set forth in the material which follows.

Saint Elizabeths Hospital

---

1. Inpatient psychiatric care
(Title 24 U.S. Code, Section 161)

1987 Authorization: Indefinite

	1986 Appropriation	1986 Available after Sequestering	1987	Increase or Decrease
Obl.	$67,614,000	$65,689,000	$69,575,000	$+3,886,000
BA	(27,772,000)	(26,578,000)	(23,047,000)	(-3,531,000)

Purpose and Method of Operation

This activity provides services to patients who need 24-hour care and treatment in a psychiatric hospital. Inpatient treatment includes evaluation, consultation, program development and development of new approaches to the care and treatment of patients. This includes the administrative support that is an integral part of that service.

Rationale for the Budget Request

The Hospital expects to treat an average of 1,469 inpatients in FY 1987 as compared to 1,545 in FY 1986. The FY 1987 budget will enable the hospital to meet inflationary increases.

Details are itemized below:

Increases:	
Built-in:	
1. Within-grade increases..	+1,262,000
2. Social Security payment..	+100,000
3. Travel and transportation..	+16,000
4. Medical-surgical services contract..	+166,000
5. Maintenance and repair of medical equipment..	+30,000
6. Other contractual services..	+44,000
7. Medical supplies, including drugs..	+97,000
8. Food, bedding, and clothing..	+108,000
9. Other supplies..	+118,000
10. Equipment..	+20,000
Subtotal..	+1,961,000
Program:	
1. Maintenance of current program level..	+1,925,000
Total increase..	+3,886,000
(Budget authority)..	(-3,531,000)

2. Inpatient custodial care pending court ordered outplacement (Title 24 U.S. Code, Section 161)

1987 Authorization: Indefinite

	1986 Appropriation	1986 Available after Sequestering	1987	Increase or Decrease
Obl.	$8,864,000	$8,648,000	$9,021,000	$+373,000
BA	(---)	(---)	(---)	(---)

Purpose and Method of Operation

This activity includes all patients who do not require acute or residential rehabilitative psychiatric care. Although they may not be completely free of symptoms, any problematic behavior they manifest does not differ significantly from that of patients usually served in residential programs in the community. The average patient load in this category is not expected to decrease but stay at approximately 106 patients.

Rationale for the Budget Request

Net funding needs for FY 1987 is at same level as FY 1986. The only change is normal mandatory increases.

Details are itemized below:

Increases:	
Built-in:	
1. Within-grade increases....................................	+115,000
2. Social Security payment..................................	+10,000
3. Travel and transportation................................	+2,000
4. Maintenance and repair of medical equipment..............	+4,000
5. Medical supplies, including drugs.........................	+9,000
6. Food, bedding and clothing...............................	+10,000
7. Other supplies..	+7,000
Subtotal..	+157,000
Program:	
1. Maintenance of current program level......................	+216,000
Total increase..	+373,000
(Budget authority)..	(---)

BEST COPY AVAILABLE

3. Area D - Community Mental Health Center (CMHC) Outpatients
(Title 24 U.S. Code, Section 161)

1987 Authorization: Indefinite

	1986 Appropriation	1986 Available after Sequestering	1987	Increase or Decrease
Obl.	$2,553,000	$2,491,000	$2,627,000	$+136,000
BA	(---)	(---)	(---)	(---)

Purpose and Method of Operation

The Center provides comprehensive inpatient and outpatient mental health services to the residents of catchment Area D of the District of Columbia. Delivery of services is accomplished using the community mental health center model, which provides for an integrated service system consisting of 24-hour inpatient services, emergency and crisis services, day treatment and partial hospitalization, outpatient services and consultation and education. Delivery of outpatient services to residents of Area D is reflected in this portion of the budget.

Rationale for the Budget Request

Budget authority for this service is eliminated on the assumption that these costs will be borne, in full, by reimbursement income from the District of Columbia government. The FY 1987 budget will maintain the current level of effort with built-in increases.

Details are itemized below:

Increases:	
Built-in:	
1. Within-grade increases	+40,000
2. Social Security payment	+6,000
3. Travel and transportation	+1,000
4. Maintenance and repair of medical equipment	+3,000
5. Other contractual services	+3,000
6. Medical supplies, including drugs	+3,000
7. Food, bedding and clothing	+9,000
8. Other supplies	+5,000
9. Equipment	+4,000
Subtotal	+74,000
Program:	
1. Maintenance of current program level	+62,000
Total increase	+136,000
(Budget authority)	(---)

BEST COPY AVAILABLE

4. Outpatient, day care and outplacement activities, other than Area D (CMHC)
(Title 24 U.S. Code, Section 161)

1987 Authorization: Indefinite

	1986 Appropriation	1986 Available after Sequestering	1987	Increase or Decrease
Obl.	$5,861,000	$5,692,000	$6,021,000	$+329,000
BA	(2,581,000)	(2,470,000)	(2,361,000)	(-109,000)

Purpose and Method of Operation

This account covers all non-Area D outpatients served by Saint Elizabeths Hospital, and includes evaluation, consultation and program development, and day care programs providing structured therapeutic activities for patients coming from inpatient wards or the community. This activity includes development of specialized monitoring and outplacement opportunities for patients, excluding direct clinical services. Outplacement services also include consultation and public education to increase community resources, and to facilitate public acceptance of the mentally ill. Community-based transitional service programs are funded from this account.

Rationale for the Budget Request

The FY 1987 estimate assumes implementation of the Dixon Plan commitment for the hospital. To meet the Dixon obligations the Hospital will continue the details of 8 persons to work with the District in caring for the outpatients transferred to District of Columbia rolls. In addition, further details may occur consistent with the transitional services planned pursuant to Public Law 98-621. The hospital has adopted a "continuum of care" model, which includes admission, acute treatment and active preparation for outplacement. The FY 1987 request will maintain the current level of effort plus built-in increases.

Details are itemized below:

Increases:	
Built-in:	
1. Within-grade increases	+82,000
2. Social Security payment	+6,000
3. Travel and transportation	+9,000
4. Outplacement contracts	+44,000
5. Maintenance and repair of medical equipment	+1,000
6. Medical supplies, including drugs	+3,000
7. Food, bedding and clothing	+5,000
8. Other supplies	+6,000
9. Equipment	+4,000
Subtotal	+160,000
Program:	
1. Maintenance of current program level	+169,000
Total increase	+329,000
(Budget authority)	(-109,000)

5. Research
(Title 24 U.S. Code, Section 161)

1987 Authorization: Indefinite

	1986 Appropriation	1986 Available after Sequestering	1987	Increase or Decrease
Obl.	$3,734,000	$3,734,000	$3,891,000	$+157,000
BA	(---)	(---)	(---)	(---)

Purpose and Method of Operation

This activity includes support services for the William A. White Division which houses patients who are the subject of studies conducted by the intramural research program of the National Institute of Mental Health.

Rationale for the Budget Request

This program supports the Hospital's longstanding commitment to continued excellence in clinical and applied research. The full year cost of this research activity will be fully reimbursed from the NIMH intramural research account.

Details are itemized below:

Increase:
  Built-in:

1. NIMH support for pay raise and inflationary cost............	+157,000
Total increases...	+157,000
(Budget Authority)..	(---)

6. Training
(Title 24 U.S. Code, Section 161)

1987 Authorization: Indefinite

	1986 Appropriation	1986 Available after Sequestering	1987	Increase or Decrease
Obl.	$2,665,000	$2,586,000	$2,742,000	$+156,000
BA	(1,329,000)	(1,272,000)	(1,215,000)	(-57,000)

Purpose and Method of Operation

Included in this activity are programs which provide: (a) accredited pre-service clinical training for students, interns, and residents in psychiatry and other related mental health specialties; (b) a wide diversity of in-service clinical training for the major mental health disciplines; (c) formal continuing education for staff psychiatrists, other physicians, clinical psychologists, and psychiatric nurses; (d) social education and consultation for public and private agencies which serve the mentally ill; and (e) annual and periodic staff development activities and education programs on contemporary mental health issues. Hospital trainees provide direct clinical services to patients.

Rationale for the Budget Request

The pre-service clinical training programs are a key source of recruitment in filling SEH staff vacancies. In-service training enhances the quality of patient treatment and care. Continuing education programs help support a goal of developing and maintaining qualified professional staff.

Details are itemized below:

Increases:	
Built-in:	
1. Within-grade increases	+49,000
2. Social Security payment	+4,000
3. Other contractual services	+12,000
4. Maintenance and repair of medical equipment	+2,000
5. Other supplies	+9,000
6. Equipment	+1,000
Subtotal	+77,000
Program:	
1. Maintenance of current program level	+79,000
Total increases	+156,000
(Budget authority)	(-57,000)

7. Program Support
(Title 24 U.S. Code, Section 161)

1987 Authorization: Indefinite

	1986 Appropriation	1986 Available after Sequestering	1986 Revised Estimate[1]	1987	Increase or Decrease
Obl.	$41,632,000	$40,362,000	$40,284,000	$42,877,000	$+2,593,000
BA	(12,014,000)	(11,497,000)	(11,497,000)	(9,730,000)	(-1,767,000)

Purpose and Method of Operation

This activity includes all the administrative and management services at Saint Elizabeths Hospital that are not an integral part of the inpatient services, day treatment programs, outpatient services, outplacement services, research programs, or training programs. It includes all cost for utilities.

Rationale for the Budget Request

The FY 1987 request will maintain the current level of effort plus built-in increases. It also includes the cost of an audit of annual leave, as required by the transfer legislation.

Details are itemized below:

Increases:	
A. Built-in:	
1. Within-grade increases	+520,000
2. Social Security payment	+49,000
3. Payment of Office of Federal Employees Compensation	+328,000
4. Transportation - motor pool	+1,000
5. Utility costs	+152,000
6. Printing costs	+4,000
7. Other contractual services	+89,000
8. Other supplies	+68,000
9. Equipment	+12,000
Subtotal	+1,223,000
B. Program:	
1. Audit of accrued leave	+100,000
2. Maintenance of current program level	+1,270,000
Subtotal, program	+1,370,000
Total increases	+2,593,000
(Budget authority)	(-1,767,000)

---

[1] Excludes $78,000 withheld as required by the Treasury, Postal Service, and General Government Appropriations Act, 1986.

SAINT ELIZABETHS HOSPITAL

Estimates for Consulting Services

Evaluation: Evaluation: Account Title	Type[1]	Funds	FY 1985	FY 1986 Appropriation	FY 1986 Revised	FY 1987
Saint Elizabeths Hospital Salaries and expenses	---	---	$ ---	$ ---	$ ---	$ ---
Subtotal, evaluation..............			---	---	---	---
Non-Evaluation:						
Saint Elizabeths Hospital Salaries and expenses	C	A	11,000	675,000	75,000	675,000
Subtotal, non-evaluation...............			11,000	675,000	75,000	675,000
Total, consulting services			11,000	675,000	75,000	675,000

TOTALS:	FY 1985	FY 1986 Appropriation	FY 1986 Revised	FY 1987
Contractual services...................	11,000	675,000	75,000	675,000
Personnel appointments.................	---	---	---	---
Advisory committee expenses............	---	---	---	---
Total, consulting services...........	11,000	675,000	75,000	675,000

1/ C indicates contractual services
2/ A indicates appropriated funds

Narrative for Consulting Services:

Management Improvement and Productivity Studies-Cost Allocation and Automated Study.	$400,000

These studies will provide data relative to current manpower and fiscal resource usage, work methodologies, and changing or developing service requirements. The findings will provide a basis for more efficient distribution of fiscal and manpower resources and attribution of costs among hospital functions as well as tenant groups. The data gained from these studies will also assure that the services being provided utilize the most cost-efficient operating procedures.

Purchase Orders
Management Improvement and Productivity Studies-Productivity and Analysis. $200,000

In accordance with the revised guidelines of OMB Circular A-76, specific activities at Saint Elizabeths Hospital have been identified for the conduct of management studies/productivity analysis during Fiscal Year 1987. These studies shall provide valuable data relative to services provided, including current manpower and fiscal resource usage, current work methodologies, and changing or developing service requirements. The findings of these studies will afford SEH an opportunity, as needed, to realign both fiscal and manpower resource usage planning, cost allocation of Hospital services or services to tenant groups, and methods of service delivery to provide the highest level of services, while assuring that such services utilize the most cost-efficient operating procedures.

Miscellaneous Purchase Orders $75,000

Funds will be used for accreditation readiness projects and clinical consultant services not available at the Hospital.

FY 1986 Revised

Due to the "Balanced Budget and Emergency Deficit Control Act of 1985", A-76 management studies in the amount of $600,000 have been eliminated.

Detail of Permanent Positions

	1985 Actual	1986 Estimate	1987 Estimate
ES-4	5	5	5
ES-3	---	---	---
ES-2	1	1	1
ES-1	---	---	---
ES-0	1	1	1
Subtotal	7	7	7
GS/GM-15	115	115	115
GS/GM-14	94	94	94
GS/GM-13	88	88	88
GS-12	221	221	221
GS-11	318	318	318
GS-10	14	14	14
GS-09	261	261	261
GS-08	71	71	71
GS-07	392	392	392
GS-06	670	670	670
GS-05	207	207	207
GS-04	70	70	70
GS-03	5	5	5
GS-02	2	2	2
GS-01	1	1	1
Subtotal	2,529	2,529	2,529

Detail of Permanent Positions

	1985 Actual	1986 Estimate	1987 Estimate
Commissioned Officers of the Public Health Service:			
CC-07, $39,017 to $56,855....................	1	1	1
CC-06, $28,919 to $49,957....................	9	9	9
CC-05, $23,130 to $40,759....................	10	10	10
CC-04, $19,494 to $34,085....................	18	18	18
CC-03, $18,119 to $29,477....................	13	13	13
CC-02, $15,797 to $21,874....................	2	2	2
CC-01, $13,716 to $17,251....................	7	7	7
Subtotal..............................	60	60	60
Ungraded....................................	789	789	789
Total permanent positions...............	3,385	3,385	3,385

Saint Elizabeths Hospital

Patient Load Data

	FY 1985 Actual	FY 1986 Estimate	FY 1987 Estimate
Program output data			
Average Daily Inpatient Load:			
District of Columbia residents.	1,407	1,337[3]	1,270[3]
U.S. Nationals.................	4	4	4
Military.......................	14	13	13
D.C. Non-residents.............	142	135	128
Virgin Islands.................	27	26	24
Other..........................	30[1]	30	30
Total inpatients...............	1,624	1,545	1,469
Outpatients on Rolls, Start of Year..........................	2,764	2,800[2]	2,800[2]
Patient Census & Movement Data:			
On Rolls, start of year........	4,454	4,199[3]	3,956[3]
Admissions.....................	+3,172	+3,013	+2,862
Discharges.....................	-3,346	-3,179	-3,020
Deaths.........................	-81	-77	-73
On rolls, end of year..........	4,199	3,956	3,725

[1] Assumes constant number in other category.

[2] Assumes constant number of outpatients.

[3] Assumes 5% reduction in inpatient load, admissions, discharges, and deaths each fiscal year.

Saint Elizabeths Hospital

Reimbursement Detail

	1985 Actual	1986 Appropriation	1986 Available After Sequestering	1987 Estimate
Federal Funds:				
U.S. Nationals..............	$328,471	$492,000	$492,000	$387,000
General Services Administration..............	18,978	23,000	23,000	24,000
NIMH intramural research....	3,570,000	3,734,000	3,734,000	3,891,000
Military....................	1,217,903	828,000	828,000	868,000
Other patient categories....	244,487	213,000	213,000	214,000
Federal financial participation (Medicaid)...	11,128,899	12,875,000	12,875,000	12,587,000
Total federal sources.....	16,508,738	18,165,000	18,165,000	17,971,000
Trust Funds:				
Soc. Sec. (Medicare......... payments)	3,354,220	3,235,000	3,235,000	3,241,000
Non-Federal Funds:				
District of Columbia.........	55,801,694	65,377,000	65,377,000	76,798,000
Cafeteria sales..............	265,983	271,000	271,000	272,000
Sale of scrap................	3,617	6,000	6,000	6,000
Private payments.............	1,346,665	1,225,000	1,225,000	1,174,000
Virgin Islands..............	1,301,717	948,000	948,000	939,000
Total non-federal........	58,719,676	67,827,000	67,827,000	79,189,000
Total reimbursements.....	78,582,634	89,227,000	89,227,000	100,401,000
Average inpatient per diem cost.......................	$224.47	$229.87	$222.36	$234.90

BLANK PAGE

WEDNESDAY, MARCH 19, 1986.

CENTERS FOR DISEASE CONTROL

WITNESSES

DR. JAMES O. MASON, DIRECTOR, CENTERS FOR DISEASE CONTROL

DR. DONALD R. HOPKINS, DEPUTY DIRECTOR, CENTERS FOR DISEASE CONTROL

DR. JOHN V. BENNETT, ACTING DIRECTOR, CENTERS FOR INFECTIOUS DISEASES, CENTERS FOR DISEASE CONTROL

DR. J. MICHAEL LANE, DIRECTOR, CENTER FOR PREVENTION SERVICES, CENTERS FOR DISEASE CONTROL

DR. J. DONALD MILLAR, DIRECTOR, NATIONAL INSTITUTE FOR OCCUPATIONAL SAFETY AND HEALTH, CENTERS FOR DISEASE CONTROL

CLAUDE F. PICKELSIMER, JR., DIRECTOR, FINANCIAL MANAGEMENT OFFICE, CENTERS FOR DISEASE CONTROL

DENNIS P. WILLIAMS, ACTING DEPUTY ASSISTANT SECRETARY FOR BUDGET, OFFICE OF THE SECRETARY

DR. VERNON HOUK, DIRECTOR, CENTER FOR ENVIRONMENTAL HEALTH

DENNIS TOLSMA, CENTER FOR HEALTH PROMOTION AND EDUCATION

Mr. NATCHER. At this time, we take up the budget request for the Centers for Disease Control. And we have before the Committee Dr. James O. Mason.

Dr. Mason, it is a pleasure to have you back before the Committee. But before you give us your statement, tell us who you have with you there, at the table.

Dr. MASON. I would be delighted to do that, Mr. Chairman. Sitting directly to my right is Dr. Donald Hopkins, who is the Deputy Director of CDC. Next to him is Dr. Donald Millar, who is the Director of the National Institute for Occupational Safety and Health. And next to him is Dennis P. Williams, who is the Acting Deputy Assistant Secretary for Budget in the Office of the Secretary.

On this side of me, right next to me, is Claude F. Pickelsimer, who directs our Financial Management Office. Next to him is Dr. John V. Bennett, who is Acting Director of the Center for Infectious Disease. And on my far left is Dr. J. Michael Lane, who is the Director of the Center for Prevention Services.

Mr. NATCHER. We are delighted to have all of you before the Committee and Dr. Mason, we will be pleased to hear from you at this time.

BUDGET REQUEST HIGHLIGHTS

Dr. MASON. I want to emphasize, Mr. Chairman and members of the Subcommittee, how delighted we are to be here to support the 1987 request for the Centers for Disease Control. You have my total statement and we submit that, with your approval, for the record and I will just hit some of the highlights of the past year.

Acquired Immunodeficiency Syndrome, or AIDS, this continues to be the nation's most visible health problem. As of March 17th, two days ago, there had been 18,404 cases and 9,780 deaths reported in the United States. That is about double the number of cases and deaths that we reported to you one year ago.

During the past year, CDC has taken extensive actions to protect the nation's blood supply, working cooperatively with FDA. We have developed a national plan for AIDS prevention and control. We are supporting community based risk reduction projects and we have issued a series of national guidelines in many critical areas.

So, although I understand it was asserted in one of your hearings that CDC was only collecting statistics, we would like the Subcommittee to know that we are not only providing command responsibility, but we have CDC people out in the states, in the trenches, actually engaged in our fight against this horrible disease.

In the 1987 budget, funds for Public Health Service AIDS activities are combined under the Office of the Assistant Secretary for Health. But CDC will continue to be responsible for the operation of its portion of the AIDS activities.

Apart from AIDS, infectious diseases are among the greatest causes of morbidity in the United States. Our programs, as you know, include grants to states for immunization and for sexually transmitted disease control activities.

We continue epidemiologic surveillance and laboratory research designed to enhance the effective use of vaccines and application of preventive techniques at the state and local level.

In 1985, we maintained immunization coverage at record high levels and the incidence of childhood diseases remained at record lows. Measles was below—and the next chart will indicate this—3,000 cases for the fourth straight year, despite importations and pockets of susceptibles that have prevented us from eliminating indigenous transmission altogether.

The state and local STD programs prevented an estimated 171,000 new gonorrhea infections and 5,500 syphilis infections in the past year.

And the chart shows that primary and secondary syphilis morbidity has decreased 9.4 percent this year, the third consecutive decrease that we have experienced. Unfortunately, gonorrhea has shown about a 6 percent increase, comparing 1985 with 1984.

Much work remains to be done to control infectious diseases, particularly in the area of chlamydia control and prevention, and then getting at the problem of Hepatitis B infection.

We are working with state and local health departments and private practitioners to promote adoption of the national recommendations for adult immunizations including use of the new Haemophilis B vaccine for children, a new vaccine that we feel would improve their health.

In the area of chronic and environmental disease prevention, we are attacking problems with the same fervor and expertise that we have attacked infectious diseases. We are going after chronic diseases and environmental health problems.

Heart disease and cancer combined contribute over 3.3 million years of potential life lost annually. Unintentional injuries cause 3.4 million years of potential life lost, more than any other health problem. Problems of this magnitude are no longer acceptable.

We now have public health interventions which we can apply to prevent many of these chronic conditions and their consequences. If people in communities would apply current interventions, we estimate that half of all injury related deaths—about 70,000—could be prevented.

In the area of chronic disease control, we have evaluated a community exercise program on the Zuni Indian reservation.

The next chart shows that there were significant health benefits for diabetics who participated in this exercise program. Over two years, the average weight loss among participants was nine pounds, compared with two pounds for non-participants.

But even more significant, 29 percent of the participants who were engaged in this no longer required insulin or other drugs to control their blood sugar, as compared to 3 percent of the non-participants. This shows that for a disease like diabetes, you can do something about the problem and get people off of medication.

Our strategy in health promotion and chronic disease prevention is to work closely with the National Institutes of Health and state and local health departments to assist in translating research into public health approaches that can significantly reduce chronic diseases in our U.S. population.

With regard to occupational safety and health, each year about one out of every ten workers in private industry suffers an occupational injury. About four out of every 100 workers is disabled and about seven out of every 100,000 workers are killed on the job.

The National Institute for Occupational Safety and Health has identified—and they are listed on the chart—the ten leading work related diseases and injuries.

In 1985, we convened a national conference of leaders in industry, labor unions, health professional organizations, and academia to develop strategies to address the first five of those problems. During Fiscal Year 1986 we will address the other five.

NIOSH completed over 550 health hazard evaluations in 1985. Many things are occurring which are having a direct effect upon this serious health and injury problem.

With regard to infant health, our FY87 budget request includes $1.7 million for CDC components of the Public Health Service Infant Health Initiative. We are going to ensure infants a healthy start in life as one of our highest priorities.

There has been extensive public concern about the disparity in rates of infant mortality and low birth weight between blacks and whites. Because the etiology of these problems is complex, there are no simple solutions. For example, even when factors related to economic status such as education are controlled, infants born to black women still have twice the risk of having low birth weight and dying during the first year of life.

The next chart shows that the risk of low birth rate is strongly associated with preventable maternal behaviors during pregnancy, such as the use of cigarettes, alcohol, and poor nutrition. This chart indicates that in Missouri we found that, regardless of other risk factors, smoking doubles the risk of low birth weight. Infants whose mothers also smoke have a 25 percent chance of being born with low birth rate. This is one of the key areas that states will be investigating through our initiative.

We completed, last year, the first national linkage of infant birth and death records that has occurred since 1960. This analysis provides a common data base for states to use in further assessing the contribution of low birth weight to infant mortality.

Our budget request for FY 1987 is $379.8 million. We are also requesting 4,015 FTEs which includes 339 reimbursable FTEs. The revised FY 1986 budget request for CDC is $367.2 million, not including $50 million for aid which is budgeted in the Office of the Assistant Secretary for Health on a comparable basis.

Mr. Chairman, we would be pleased to answer any questions from the Committee.

[The prepared statement of James O. Mason, M.D. follows:]

GRAMM-RUDMAN REPORT

Mr. Natcher. Thank you very much, Dr. Mason.

Pursuant to the Gramm-Rudman law, in 1986 your agency, as you know, loses $20,290,000 in budget authority. At this point in the record, we will insert your report to the Committee on sequestration.

[Information to be furnished follows:]

OPENING STATEMENT
DEPARTMENT OF HEALTH AND HUMAN SERVICES
STATEMENT BY JAMES O. MASON M.D., Dr. P.H.
DIRECTOR, CENTERS FOR DISEASE CONTROL
"Disease Control, Research, and Training"

Mr. Chairman and Members of the Committee: It is a pleasure to be here to support the 1987 budget request for the Centers for Disease Control (CDC).

CDC's overriding goal is prevention of unnecessary illness and premature death. We strive to achieve the national prevention objectives through surveillance, epidemiologic investigations, and laboratory research; by serving as national and international reference laboratories; by providing assistance, including grants, to State and local health departments; and by disseminating our findings through our other partners in academic institutions, medical care settings, and business and labor groups. During 1985, for example, our epidemiologists investigated over 680 outbreaks.

During the past 18 months, CDC has reexamined our Nation's health problems with the specific goal of identifying those areas in which there are significant opportunities to improve the health of people in this country. The reduction of infant mortality by deterring smoking during pregnancy, prevention of invasive cervical cancer, and prevention of injuries for older adults and minority groups are among the highest priorities we identified. This effort sharpened our focus on areas in which measurable improvements in morbidity, mortality, or quality of life can be achieved or anticipated using approaches that are feasible and appropriate for CDC. CDC's strategy for the future is to maintain our current expertise in prevention of a diverse array of problems while focusing on these new challenges to the extent possible.

I would like to highlight a few of CDC's recent achievements and contributions to the application of public health practices at the community level, and illustrate the future directions of CDC's programs in five areas.

Acquired Immunodeficiency Syndrome (AIDS)

AIDS continues to be the nation's most visible health problem. As of February 28, 1986, there had been 17,859 cases and 9,463 deaths, about double the number of cases and deaths we reported to you last February. [chart]

Some progress has been made, however, toward controlling the spread of AIDS. Let me share with you a few accomplishments of the past year:

- To hasten the transfer of the HTLV-III serologic test for screening blood and plasma to protect the blood supply, CDC trained 145 laboratorians from 47 States in use of the HTLV-III serologic test; awarded cooperative agreements to 55 areas to establish alternate sites; and conducted 35 courses on pre- and post-test counseling for over 500 professionals. In cooperation with the Atlanta Red Cross, we demonstrated that the tests introduced for use by blood and plasma collection facilities were highly accurate in that setting. This study validated the use of the serologic testing procedure to reduce the risk to the nation's blood supply.
- CDC laboratory scientists discovered how the AIDS virus attaches to and infects host cells. Understanding of this mechanism increases the chance of developing a vaccine and effective treatment methods.
- CDC provided leadership in developing the overall Public Health Service plan for prevention and control of AIDS. We are also providing assistance to State health departments to support community-based information, education, and risk reduction activities.
- We developed national guidelines and recommendations for serologic screening of blood and plasma; reducing sexual and drug abuse transmission; preventing perinatal transmission; preventing transmission of infection in the workplace; and for education and foster care of infected children.

- The first International Conference on AIDS was held in Atlanta in April. Three thousand participants from 50 countries exchanged scientific information, and reviewed AIDS prevention and control strategies.

In the 1987 budget, funds for Public Health Service AIDS activities are combined under the Office of the Assistant Secretary for Health, but CDC will continue to be responsible for the operation of its portion of the AIDS activities. Within this budget, CDC plans to maintain support for AIDS surveillance systems, epidemiologic studies, laboratory work in virology and immunology, health education/risk reduction efforts, and development of more effective prevention and control strategies.

Infectious Disease Prevention

Apart from AIDS, infectious diseases are among the greatest causes of morbidity in the United States. Our best estimates indicate that 20-30% of all infections and 50% of deaths attributed to infections are preventable. Our programs include grants to States for immunization and sexually transmitted disease (STD) control activities, epidemiologic surveillance and laboratory research designed to enhance the effective use of vaccines, and application of preventive techniques at the State and local level. By working closely with our public health partners in communities throughout this country, in 1985:

- We maintained immunization coverage at record high levels of over 97% for measles, rubella, mumps, and polio, and diphtheria/pertussis/tetanus for children entering school. No cases of diphtheria or congenital rubella syndrome and only two cases of tetanus were reported in children under age 15. Record low numbers of cases of rubella and mumps were reported. Measles was below 3,000 cases for the 4th straight year despite importations and pockets of susceptibles that have prevented us from eliminating indigenous transmission altogether. [chart]

BEST COPY AVAILABLE

Partly as a result of U.S. accomplishments in controlling vaccine-preventable diseases among children, countries of the Western Hemisphere, including the U.S., declared the goal of polio eradication by 1990. A number of other countries have embraced the goal of measles elimination. These actions are increasingly important to our domestic epidemiological situation.

- Support for State and local STD programs prevented an estimated 171,000 new gonorrhea infections and 5,500 syphilis infections. Primary/secondary syphilis morbidity decreased by 9.4%; the third consecutive year the rate has decreased. [chart]
- In collaboration with State health agencies and the Food and Drug Administration, CDC investigated two major epidemics: in Illinois, the largest outbreak of salmonellosis in U.S. history; and in California, an epidemic of listeriosis. The salmonella investigation revealed that the strain of salmonella was linked to two brands of milk from the same dairy plant which were not pasteurized properly. The listeriosis outbreak, which had over 140 cases and a 30% mortality rate, ended after manufacture of the cheese associated with the epidemic was suspended.

Much work remains to be done to control infectious diseases, however, for example:

- An estimated 3 to 4 million Americans suffer from chlamydia infections each year. Demonstration projects are underway to identify the key risk factors and evaluate our 1985 chlamydia control guidelines.
- To prevent bacterial meningitis among children and vaccine-preventable diseases such as pneumococcal pneumonia among high risk adults, CDC is working with State and local health

departments and private practitioners to promote adoption of the national recommendations for adult immunizations and use of the Haemophilis influenzae b vaccine for children.

Chronic and Environmental Disease Prevention

Over 75% of the deaths in the United States each year are caused by chronic diseases, in children and adults. Heart disease and cancer combined contribute to over 3.3 million years of potential life lost annually. Unintentional injuries cause 3.4 million years of potential life lost, more than any other health problem. Almost 4% of children under 17 years of age have chronic conditions that limit their activities. For persons 17 years of age and over, about 18% have limitations due to chronic diseases. These conditions are frequently the result of exposure to environmental hazards, genetic factors, and health and injury-related behaviors such as cigarette smoking, and lack of access and use of preventive measures such as high blood pressure control and pap smear testing. Chronic disease problems of this magnitude are no longer acceptable, because public health interventions are available or can be developed to prevent these conditions and their consequences.

CDC's program in chronic and environmental disease prevention is analogous to our approach to infectious disease prevention. We are working with State and local health and environmental agencies to help build their capacity in environmental health, chronic disease control, injury prevention and health promotion.

Recent achievements in these important areas are:

- Some 40 studies were begun to measure the health effects of exposures to toxic substances such as arsenic, polychlorinated biphenyls, lead, and dioxin. Our scientists are developing new methods for measuring body burdens of toxic substances and detecting the early stages of kidney or liver dysfunction.
- CDC assisted 7 States in investigating unusual clusters of injuries or fatalities. For example, an analysis of hospital admissions found that 9% of deaths in Alaska in 1983-84 resulted from transportation and recreational vehicle crashes. At least 20 of these deaths and 538 injuries were associated with 3-wheel all-terrain vehicles. Only 9% of riders wore helmets at the time of the incident. If people in communities would apply current interventions, we estimate that half of all injury-related deaths could be prevented.
- CDC's widely distributed School Health Education Evaluation findings, which we previewed in last year's hearings, allow us to state flatly that educating children about health is an effective health promotion tool. It enhances a child's working knowledge of health, and it clearly deters many children from adopting unhealthful practices such as smoking. Although over 625,000 children in 31 States participated this year in one CDC-developed curriculum, called "Growing Healthy," many children still receive little health education in schools. We are accelerating our work with States to increase the number of children benefitting from proven approaches.

- CDC's evaluation of a community exercise program on the Zuni Indian reservation demonstrated significant health benefits for diabetics who participated. Over two years, the average weight loss among participants was 9 pounds, compared with 2 pounds for nonparticipants. More significantly, 29% of the participants no longer require insulin or other drugs to control their blood sugar, as compared to 3% of the nonparticipants. [chart]
- To determine the reasons for excess mortality from invasive cervical cancer and design interventions, CDC has a collaborative project with the Department of Health in Kentucky, the State with the second highest mortality rate from this disease. An estimated 6,800 women die from invasive cervical cancer each year. In theory, all of these deaths are preventable through early detection and treatment.

Our strategy in health promotion and chronic disease prevention is to work closely with the National Institutes of Health and State and local health departments to assist in translating research into public health approaches that can significantly reduce chronic diseases. We will continue to encourage reduction of health risks such as smoking, lack of exercise and poor nutrition through school health education and community-based health promotion programs.

Occupational Safety and Health

Each year about one out of every 10 workers in private industry suffers an occupational injury, about 4 out of every 100 workers is disabled, and about 7 out of every 100,000 workers are killed on the job. The National Institute for Occupational Safety and Health (NIOSH) has identified the ten leading causes of work-related diseases and injuries as: occupational lung diseases, musculoskeletal injuries, occupational cancers, traumatic injuries, cardiovascular diseases, reproductive disorders, neurotoxic disorders, hearing loss, dermatologic conditions, and psychologic disorders. [chart] In 1985, we convened a national conference of leaders in industry, labor unions, health professional organizations, and academia to develop strategies to address the first five of these problems.

In 1985, NIOSH had substantial achievements in a number of these areas:

o NIOSH has made progress in strengthening occupational disease surveillance systems. Through cooperative agreements, 17 States are developing their ability to monitor occupational illness and injuries and to improve the accuracy of reporting. In collaboration with the National Center for Health Statistics, NIOSH developed the capability to monitor cause-specific mortality for silicosis, asbestosis, coal workers' pneumoconiosis and mesothelioma.

o Over 550 health hazard evaluations were completed.

o In anticipation of increasing use of robotics in industry, NIOSH developed a safety system integrating engineering devices and comprehensive safety procedures to protect workers who maintain and program industrial robots and automated system installations.

o In a study of workers in a veterinary hospital in Georgia, we found that exposure to fenthion was causing neurologic effects. This pesticide was applied to dogs to control fleas. Although it is unknown how many of the estimated 30,000 veterinarians and 45,000 support workers were exposed to fenthion, NIOSH recommended that its use be discontinued.

o Since control of workplace hazards is most cost-effective when built into the initial design of machinery and worksites, NIOSH initiated a project with three schools of engineering to incorporate occupational safety and health into their curricula.

In 1987 CDC will continue its national program of research, surveillance, and worksite assessments of the hazards experienced by 104 million workers. Future directions include further development of national and State surveillance systems, evaluation and development of control technology, wide dissemination of safety recommendations and policy guidances, and research on the leading causes of work-related illnesses and injuries.

Infant Health

Assuring infants a healthy start in life and enhancing the health of their mothers are among the highest priorities in public health. There has been extensive public concern about the disparities in rates of infant mortality and low birth weight between blacks and whites. Because the etiology of these problems is complex, there are no simple solutions. For example, even when factors such as education that are related to economic status are controlled, infants born to black women still have twice the risk of being low birth weight and dying during the first year of life. However, risk of low birth weight is strongly associated with preventable maternal behaviors during pregnancy, such as use of cigarettes and alcohol, and poor nutrition.

CDC has been working with other PHS agencies and State health departments to help to address excess infant mortality. For example:

- In Missouri, we found that regardless of other risk factors, smoking doubles the risk of low birth weight. For very high risk groups, infants whose mothers also smoke have a 25% chance of being born with low birth weight. This is one of the key areas that States will be addressing thro , our initiative. [chart]
- CDC epidemiologists assessed the years of potential life lost due to birth defects and found a 15.7% decrease from 1970-72 to 1980-82. Much of this decline may be attributed to improvements in the care of infants born with congenital anomalies, resulting in an increased survival rate. Since the rates of occurrence of

most birth defects have remained stable over the last decade, the decline cannot be attributed to an overall decline in incidence. Cardiovascular system defects were the leading cause of premature mortality for infants with congenital anomalies.

- Working with other PHS agencies (National Center for Health Statistics, National Institute of Child Health and Human Development, and Health Resources and Services Administration) and State health departments, we completed the first national linkage of infant birth and death records since 1960. This analysis provides a powerful common data base for States to use in further assessing the contribution of low birth weight to infant mortality and targeting their control efforts more precisely.

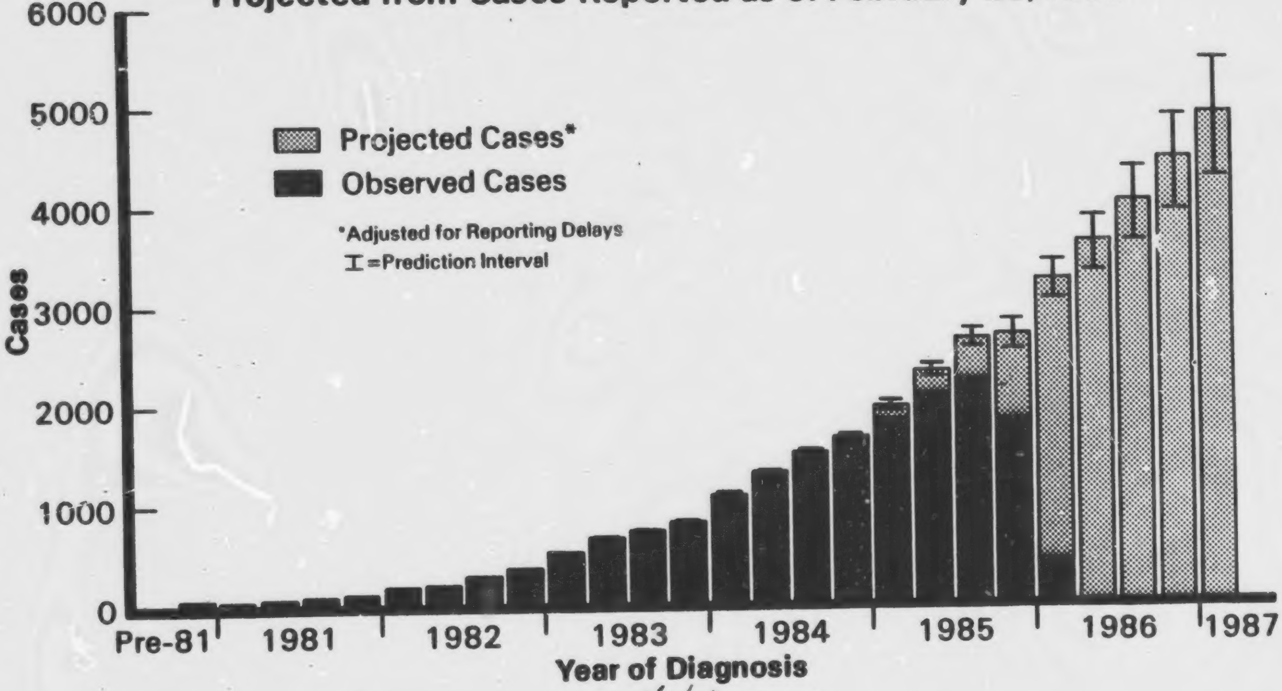
In 1987, CDC is requesting $1.7 million to fund two components of the PHS Infant Mortality Initiative. Our main role is to improve the ability of States to monitor health-related behaviors associated with poor pregnancy outcomes by enhancing two existing surveillance systems. The Pregnancy Nutrition Surveillance System, which monitors women enrolled in the public prenatal programs, and the Behavioral Risk Factor Surveillance System, which monitors adult risk factors, will be expanded to enable States to assess pregnancy-related factors such as smoking and alcohol use, determine risk groups, and develop appropriate interventions. Through this initiative, we will also work with the Health Resources and Services Administration to provide epidemiologists to assist State Maternal and Child Health Programs in assessing problems associated with infant mortality.

Budget Request

In FY 1987, we are requesting $379.8 million, which includes $1.7 million for the CDC components of the PHS Infant Mortality Initiative. We are also requesting 4,015 FTE's, which includes 339 Reimbursable FTE's. This request includes $89 million for the Preventive Health and Health Services Block Grant. We have not requested funds in 1987 for the continued expansion of the vaccine stockpile. Since several issues are pending regarding liability legislation and the possibility that new manufacturers may enter the market, completion of the stockpile will be delayed until 1988 or beyond.

The revised FY 1986 budget request for CDC is $367.2 million, not including $50.3 million for AIDS, budgeted in the Office of the Assistant Secretary for Health on a comparable basis. This amount reflects a decrease of $20.3 million for the Gramm-Rudman-Hollings reduction and $34.1 million for proposed recissions. Taking into account the amounts that were sequestered, the proposed recissions include: $1.4 million for the Prevention Research and Demonstration Centers, $4.8 million for cooperative agreements for tuberculosis control; $4.8 million for cooperative agreements for State diabetes control; $1.0 million for the designer drug study; $11.8 million for AIDS alternative test sites and AIDS hotline; $8.4 million for occupational safety and health educational resource centers; and $1.9 million for equipment for the new virology building under construction.

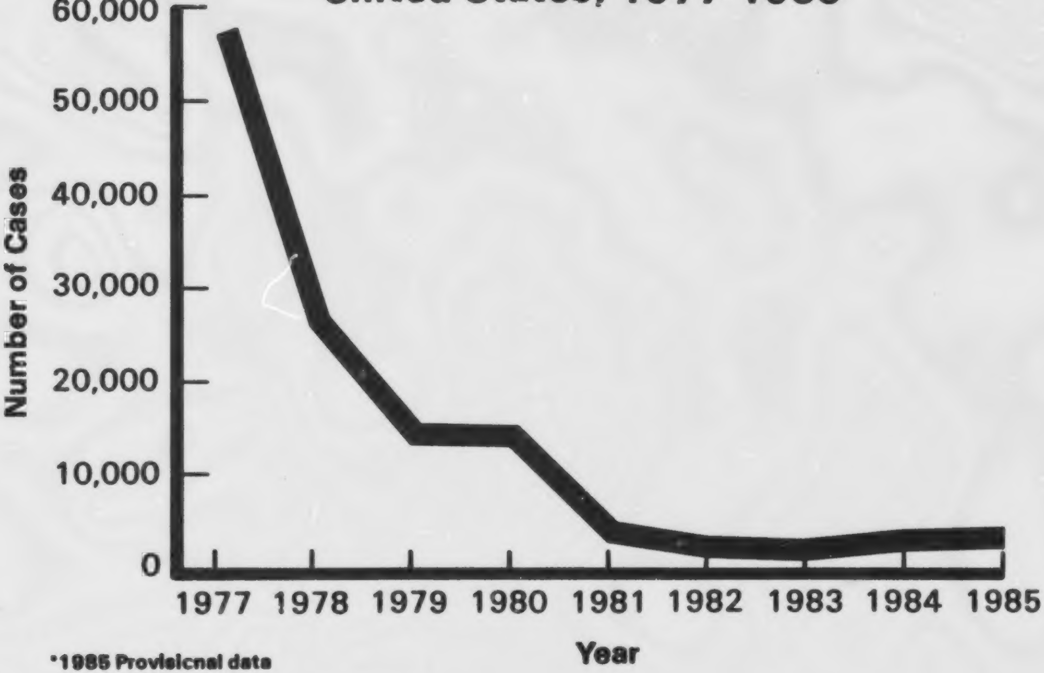
I would be pleased to answer any questions from the Committee.



Incidence of AIDS in the United States By Quarter of Diagnosis Projected from Cases Reported as of February 28, 1986

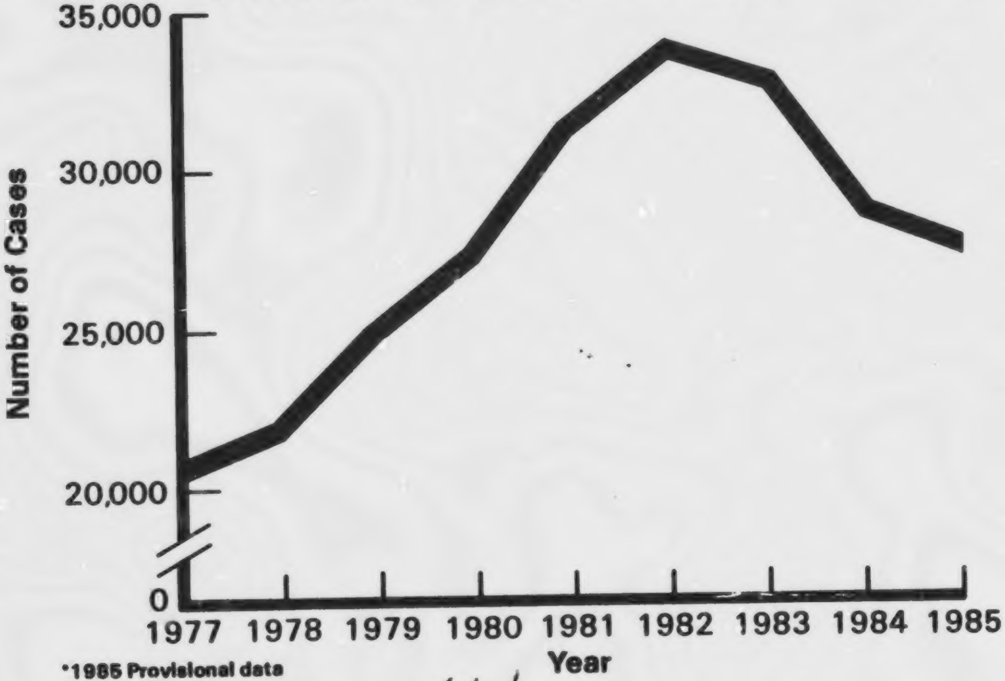
552

Reported Measles Cases United States, 1977-1985*



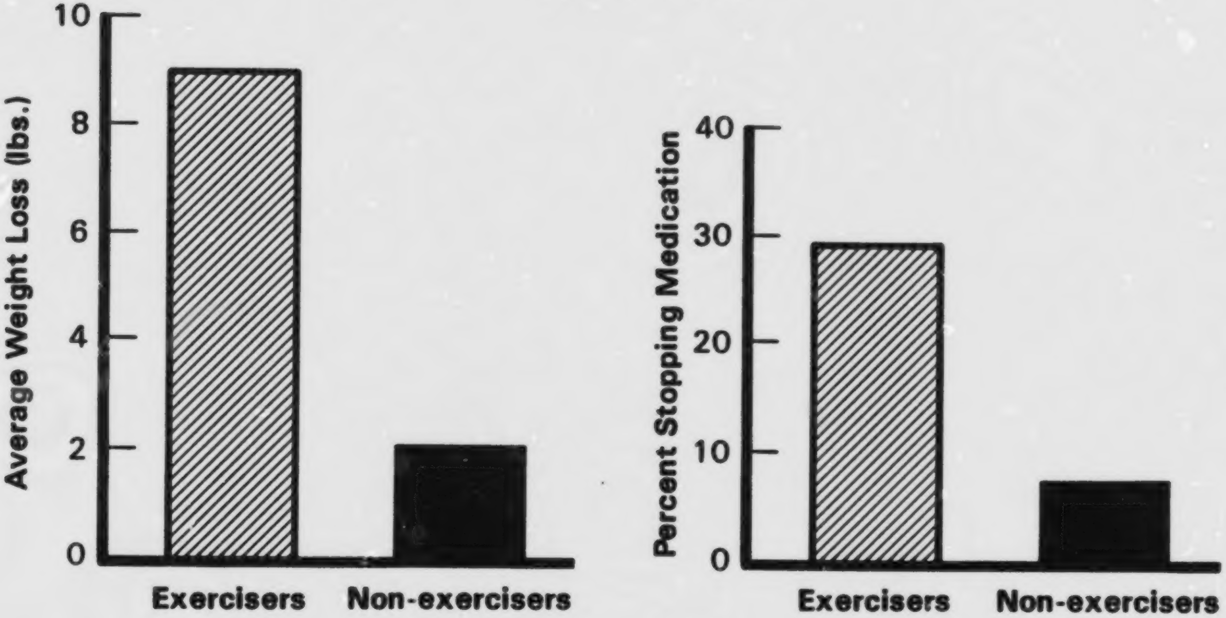
*1985 Provisional data

Reported Cases of Primary and Secondary Syphilis United States: Calendar Years 1977—1985*



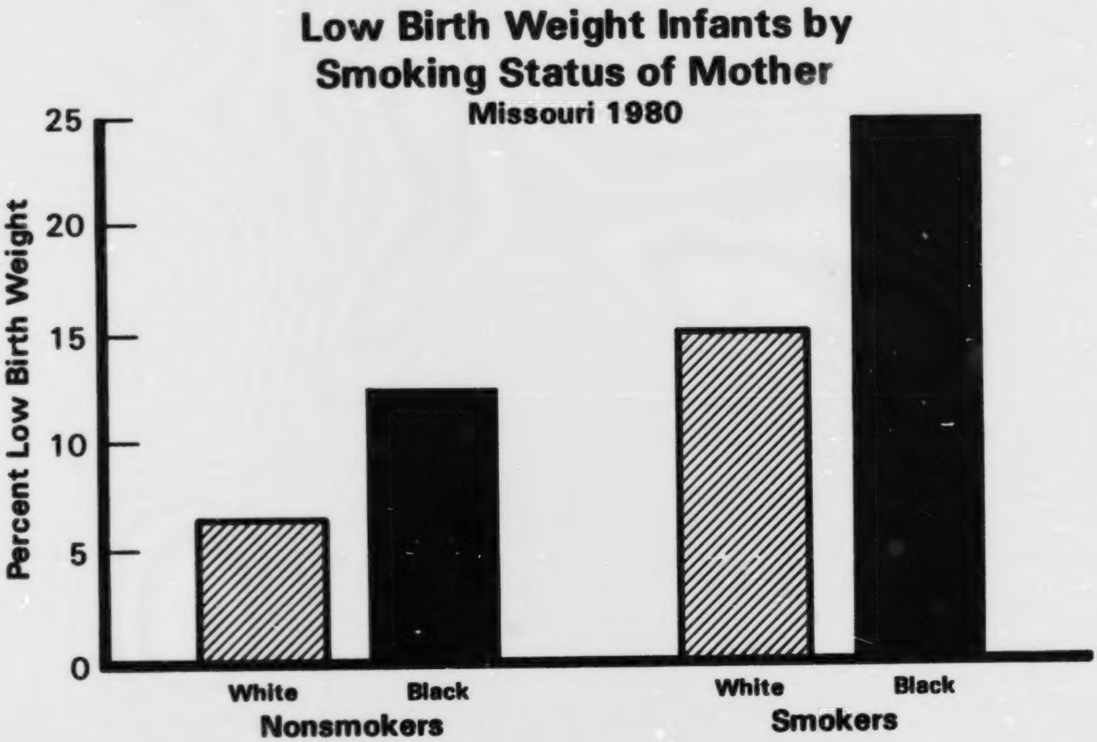
*1985 Provisional data

Effects of Community Health Promotion Program
Adult Diabetics, Zuni, New Mexico
1983-1985



Ten Leading Work-Related Diseases and Injuries

- Occupational Lung Diseases
- Musculoskeletal Injuries
- Occupational Cancers
- Severe Occupational Traumatic Injuries
- Cardiovascular Diseases in Workers
- Reproductive Disorders
- Neurotoxic Disorders
- Noise-Induced Hearing Loss
- Dermatologic Conditions
- Psychologic Disorders



Low Birth Weight Infants by Smoking Status of Mother
Missouri 1980

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control
Biographical Sketch

NAME : James O. Mason, M.D., Dr.P.H.

POSITION : Director, Centers for Disease Control

BIRTHPLACE AND DATE : Salt Lake City, Utah, June 19, 1930

EDUCATION : B.A. - 1954, University of Utah, Salt Lake City, Utah
M.D. - 1958, University of Utah, Salt Lake City, Utah
M.P.H. - 1963, Harvard School of Public Health, Boston, Massachusetts
Dr.P.H.- 1967, Harvard School of Public Health, Boston, Massachusetts
Internship, 1958-1959, Johns Hopkins Hospital, Baltimore, Md.
Residency, Internal Medicine, 1961-1962, Peter Bent Brigham Hospital, Harvard Medical Service, Boston, Massachusetts

EXPERIENCE :

1983-Present : Director, Centers for Disease Control

1983-Present : Administrator, Agency for Toxic Substances and Disease Registry

1985 : Acting Assistant Secretary for Health, Department of Health and Human Services

1979-1983 : Executive Director, Utah Department of Health

1978-1979 : Associate Professor and Chairman, Division of Community Medicine, Department of Family and Community Medicine, University of Utah College of Medicine

1976-1978 : Deputy Director of Health, Utah Division of Health

1970-1976 : Commissioner, Health Services Corporation, The Church of Jesus Christ of Latter-day Saints

1969-1970 : Deputy Director, Centers for Disease Control (CDC), DHEW, Atlanta, Georgia

1968-1969 : Chief, Infectious Diseases, Latter-day Saints Hospital and Assistant Professor, Department of Medicine and Preventive Medicine, University of Utah, College of Medicine

1964-1968 : Deputy Director, Bureau of Laboratories, Centers for Disease Control (CDC) DHEW, Atlanta, Georgia

1961 : Chief, Surveillance Section, Epidemiology Branch, Center for Disease Control (CDC), DHEW, Atlanta, Georgia,

1960 : Chief, Hepatitis Surveillance Unit, Epidemiology Branch, CDC, Atlanta, Georgia

1959 : Chief, Epidemic Intelligence Service, CDC, Atlanta, Georgia

TEACHING APPOINTMENTS : Clinical Professor, Department of Family and Community Medicine, University of Utah College of Medicine, May 1, 1979 to December, 1983

Clinical Professor, Department of Pathology, University of Utah College of Medicine, May, 1980 to December, 1983

Clinical Professor of Community Health, Emory University School of Medicine, October, 1984 to Present

ASSOCIATION MEMBERSHIP : Chairman, Utah Governor's Advisory Committee for Comprehensive Health Planning, 1975 to 1977

Chairman, Joint Residency Committee in Preventive Medicine and Public Health University of Utah College of Medicine, 1975 to 1980 Member, Utah Cancer Registry Research Advisory Committee, 1976 to 1983

Chairman of Board, Hospital Cooperative of Utah, July, 1977 to 1979 Chairman, Utah Health Planning and Resource Development Advisory Group Executive Committee 1977 to 1979

Member, Medical Association of Atlanta, 1985 to Present

Member, Institute of Medicine of the National Academy of Sciences, July, 1985 to Present

Member, twenty-two other committees or organizations

HONORS : Alpha Epsilon Delta, University of Utah 1954
Phi Kappa Phi, University of Utah, 1956
Alpha Omega Alpha, University of Utah, 1957
Roche Award, University of Utah, 1957
Wintrobe Award, University of Utah, 1958
Delta Omega, Harvard University, 1963
Sigma XI, CDC, Atlanta, 1964
Distinguished Alumni Award, University of Utah, 1973
Beatty Award, Utah Public Health Association 1979
Administrator of the Year Award, Brigham Young University, 1980
Special Award for Outstanding Public Service, American Society for Public Administration, 1984
Public Health Service Distinguished Service Medal, 1985

(Assistant Surgeon General, United States Public Health Service Commissioned Corps, effective November 29, 1933).

GRAMM-RUDMAN REPORT

Mr. NATCHER. Thank you very much, Dr. Mason.

Pursuant to the Gramm-Rudman law, in 1986 your agency, as you know, loses $20,290,000 in budget authority. At this point in the record, we will insert your report to the Committee on sequestration.

[Information to be furnished follows:]

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR DISEASE CONTROL

Disease Control

Effect of Sequestration

Program/ Activity	FY 1986 Appropriation	Sequestration (-)	FY 1986 Available After Sequestering
Preventive Health Services:			
Preventive health & health services block grants:			
Grants	$90,958,000	$3,911,000	$87,047,000
Program support	525,000	23,000	502,000
Subtotal	91,483,000	3,934,000	87,549,000
Prevention centers	1,500,000	64,000	1,436,000
Sexually transmitted diseases:			
Grants	46,511,000	2,000,000	44,511,000
Program operations	9,774,000	420,000	9,354,000
Subtotal	56,285,000	2,420,000	53,865,000
Immunization:			
Grants	47,359,000	2,036,000	45,323,000
Program operations	8,235,000	354,000	7,881,000
Vaccine stockpile	4,000,000	172,000	3,828,000
Subtotal	59,594,000	2,562,000	57,032,000
Infectious diseases:			
T.B. grants	5,000,000	215,000	4,785,000
AIDS:			
New drugs	6,900,000	297,000	6,603,000
Hot line	2,000,000	86,000	1,914,000
Alternate test sites	10,380,000	446,000	9,934,000
Other AIDS	45,645,000	1,963,000	43,682,000
Subtotal	64,925,000	2,792,000	62,133,000
Other infectious diseases	36,773,000	1,581,000	35,195,000
Subtotal	106,698,000	4,588,000	102,110,000
Chronic & environmental disease prevention:			
Diabetes grants	5,000,000	215,000	4,785,000
Designer drugs	1,000,000	43,000	957,000
Other chronic & environ. disease prevention	24,425,000	1,050,000	23,375,000
Subtotal	30,425,000	1,308,000	29,117,000

Program/ Activity	FY 1986 Appropriation	Sequestration (-)	FY 1986 Available After Sequestering
Occupational safety and health:			
Research	58,923,000	2,534,000	56,389,000
Training	8,760,000	377,000	8,383,000
Subtotal	67,683,000	2,911,000	64,772,000
Epidemic services:			
Epidemic svcs. activities	51,766,000	2,226,000	49,540,000
User fees	-466,000	-19,000	-447,000
Subtotal	51,300,000	2,207,000	49,093,000
Buildings & facilities:			
Repairs & improvements .	1,810,000	78,000	1,732,000
Equipment, virology lab.	1,987,000	85,000	1,902,000
Subtotal	3,797,000	163,000	3,634,000
Program management	3,096,000	133,000	2,963,000
TOTAL	471,861,000	20,290,000	451,571,000
Other Reductions:			
Offsetting collections (non-Federal 401(c) authority)	1,100,000	47,000	1,053,000

Effect of Sequestration

Preventive Health & Health Services Block Grant

The sequestering of $3,911,000 from block grant funds reduces the Federal share in the cost of public health programs for which State and local health departments have the primary responsibility. These grants constitute a relatively small proportion of the total State and local expenditures for public health (e.g., the percentage for FY 1983 was 1.5 percent). The decreased funding will, to varying degrees, affect such State programs as: fluoridation; rodent control; hypertension; emergency medical services; home health; rape services; risk reduction; and comprehensive public health services such as tuberculosis.

The reduction in program operations will result in fewer dollars for travel to audit State grants.

Prevention Centers

The prevention centers reduction of $64,000 will reduce the funds available for each center.

Sexually Transmitted Diseases

The proposed cutbacks of $420,000 in direct operations and $2,000,000 in grants will affect further implementation of a national chlamydia control program. Special demonstration projects aimed at developing cost-effective methodologies for the control of chlamydia will be reduced and funding for chlamydia testing, surveillance, and intervention will be discontinued.

Strategically located Regional laboratories which are planned for opening in FY 1986 and are intended to monitor and track antimicrobial resistant disease, will be deferred. In addition, planned research projects for FY 1986 will not be implemented. These include three projects whose results have potential impact upon disease control strategy nationwide and which relate to five of the six priority 1990 objectives: (1) Pelvic Inflammatory Disease (PID) - the purchase of a database from Sweden which compares results of clinical diagnoses and laparoscopy tests will be invaluable in helping to set direction for ongoing PID research; (2) Adolescent Sexually Transmitted Diseases - this project will compare STD knowledge among inner-city teenagers before and after education which emphasizes prevention methods that are particularly suitable for adolescents; and (3) Human Papillomavirus - this project will explore the epidemiology of HPV and its relation to cervical cancer.

Immunization

In FY 1985, immunization grants totaled $42.4 million, of which $26.1 million was used for the purchase of vaccine and $16.3 million was used to support State and local immunization program operations. In FY 1986, due to vaccine price increases, $36.9 million will be used to provide the same proportion of vaccine as in FY 1985; consequently, Federal support for State and local immunization program operations, including the vaccine delivery system and surveillance activities, will decrease to $8.4 million.

In addition, the Gramm-Rudman reductions in program operations will postpone the annual U.S. Immunization Survey. This survey provides information on national immunization levels which is essential for future planning and decision making.

Funds available for the purchase of vaccine for the stockpile will be reduced by $172,000, increasing the length of time to complete the stockpile.

Infectious Diseases

The sequestering of $215,000 in TB grant funds will reduce the average size of the awards by $4,434 and reduce the TB prevention level of effort by 4.3%, unless State or local funds can be used to replace the decrease.

Funds available to purchase chemotherapeutic agents for the treatment of patients with AIDS will be reduced by $297,000. The effect will be a reduction in the number of patients treated.

The reduction of $86,000 for the 24-hour AIDS hotline will decrease the level of services available to the callers by reducing the number of telephone call receivers from 39 to 35.

Alternate test site awards to States will be decreased by $446,000, or an average of $8,900 per State and will require additional State or local funding.

Since neither proven antiviral drugs nor a vaccine are available, health education/risk reduction activities (including testing and counseling among groups at risk for AIDS) are the main interventions for helping reduce the spread of HTLV-III/LAV. The $1,963,000 reduction in other AIDS activities will reduce the average size of the award to States and local health agencies by 4.3% for health education/risk reduction activities in capacity building, augmentation of existing health education/risk reduction programs, and demonstration projects. Funds available to fund innovative health education/risk reduction projects will be reduced by 4.3%. The sequestering will also decrease the size and/or number of surveillance projects and epidemiology studies. This reduction also includes a reduction of $47,000 resulting from the sequestering of 4.3% of anticipated collections from non-federal sources for services provided.

The sequestering of $1,581,000 of other infectious diseases funds will delay the purchase of state-of-the-art scientific equipment necessary to keep CDC's research and laboratory activities on the leading edge of scientific change.

Chronic and Environmental Disease Prevention

The sequestering of $215,000 of diabetes project funds will reduce the number of major complication-specific interventions funded and reduce the size of the awards to project States from $195,490 to $187,084.

A reduction of $43,000 in the new designer drugs program will reduce the number of extramural projects by one.

The sequestration of $1,050,000 in other chronic and environmental diseases prevention programs will reduce modestly (4.3%) the level of research and services provided in this activity including environmental health, community health promotion, nutrition, technology transfer, dental disease prevention, diabetes, laboratory services, and chronic diseases.

Occupational Safety and Health

The sequestering of $2,534,000 will affect both intramural and extramural research into the ten leading work-related diseases and injuries: occupational lung diseases; musculoskeletal injuries, occupational cancers; severe occupational traumatic injuries, occupationally related cardiovascular diseases; disorders of reproduction; neurotoxic disorders; noise-induced loss of hearing; dermatologic conditions; and psychologic disorders.

Sequestering of $377,000 in occupational safety and health training activities will reduce the size of the award for the 15 Educational Resource Centers by an average of $169,000. Increased university and private sector financing could replace Federal funding.

Epidemic Services

The sequestration of $2,207,000 will delay the purchase of state-of-the-art scientific equipment as it is developed and placed on the market for CDC's laboratory and surveillance activities to make them more timely and efficient.

Building & Facilities

The sequestration of $78,000 in repair and improvement activities will delay making minor repairs to the CDC facilities.

The reduction of $85,000 for equipping the not yet completed virology laboratory will result in a delay of purchasing the equipment for its efficient operation.

Program Management

The effect of sequestering $133,000 will be diminished by the improved management of travel, printing, purchases of equipment, and by the improved use of office automation.

Reimbursement from Non-Federal Sources

The effect of sequestering $47,000 of the anticipated collections from non-federal sources will require that infectious disease activities be reduced to offset the actual cost collections from non-federal users of CDC services.

In summary, except for epidemic aid surveillance, and grants to States for the purchase of vaccine, all programs within CDC will be affected, to some minor extent, by the sequestering action.

EFFECT OF REDUCTIONS

Mr. NATCHER. Describe for us, Dr. Mason, the effect that these reductions will have on the Agency in 1986.

Dr. MASON. Mr. Chairman, you have already mentioned the $20 million that is involved. The sequestration of grant funds for the prevention block grants, STD, immunization, educational resource centers, diabetes, and TB will result in lower awards, averaging 4.3 percent.

Occupational safety and health intramural and extramural research will be decreased by about $2.5 million. AIDS activities will be reduced by $2.8 million. This will reduce the size of grants to states and communities for risk reduction and health education programs.

The other programs within CDC will be affected by a reduction in the number and size of extramural projects.

Mr. NATCHER. Dr. Mason, how much of the total of $20,290,000 will be restored in the 1987 budget?

Dr. MASON. The increase from our '86 base is for cost of living. There is no restoration of the Gramm-Rudman losses.

FTE REDUCTION

Mr. NATCHER. How many full time equivalent staff will the agency lose in 1986, as a result of Gramm-Rudman?

Dr. MASON. I am not sure that all of the reduction is a direct result of Gramm-Rudman, but our total FTE allocation is 4,015, which is about 150 less than it had been in 1985.

Mr. NATCHER. Will there be any employee furloughs in CDC in 1986?

Dr. MASON. There will be no reduction in force or furloughs as a result of the Gramm-Rudman. We are trying to manage that decrease without having to do that.

Mr. NATCHER. What are your full time employee ceilings for 1986 and 1987?

Dr. MASON. 4,015 FTE for both years.

Mr. NATCHER. What was your actual level, in 1985?

Dr. MASON. In 1985, 4,161 FTE, with 4,254 on the rolls as of 9-28-85.

Mr. NATCHER. How many employees are currently on board?

Dr. MASON. We would be somewhere between the 4,254 and the 4,015. We are trying to get down to that level without having a reduction in force or furloughing.

Mr. NATCHER. Dr. Mason, it appears that you are not complying with last year's conference report that said that CDC should have 4,398 full time employees in 1986. How do you account for that, Doctor?

Dr. MASON. That is correct and I think there are two reasons for that. First of all, our funding with the sequestration and for other reasons would now not permit that level of FTEs. The other reason is the President's objective to restrain federal domestic employment. We are involved in that endeavor.

EMPLOYMENT BY BUDGET ACTIVITY

Mr. NATCHER. We note that your budget justification this year does not include some of the usual columns showing employment levels, the best example being the budget authority by activity table on page seven. Why have you omitted this employment information. Dr. Mason?

Dr. MASON. We were following directions that had been given to CDC for budget preparation.

Mr. NATCHER. From the——

Dr. MASON. From the Public Health Service and the Department of Health and Human Services.

Mr. NATCHER. Provide for the record a revised activity table showing the employment numbers.

[Information to be furnished follows:]

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL
Disease Control, Research, and Training

Budget Authority by Activity

	1986 Appropriation		1986 Available after Sequestering		1986 Revised		1987	
	FTE	Amount	FTE	Amount	FTE	Amount	FTE	Amount
Preventive Health & Health Services Block Grants:								
Grants........................	63	90,958,000	42	87,067,000	42	87,067,000	42	89,000,000
Program operations..........	10	525,000	6	502,000	6	502,000	6	525,000
Subtotal..................	73	91,483,000	48	87,549,000	48	87,549,000	48	89,525,000
Prevention Centers............	--	1,500,000	--	1,436,000 /1	--	-- /1 /2	--	--
Sexually Transmitted Diseases:								
Grants........................	448	46,511,000	397	44,511,000	397	44,511,000	397	45,510,000
Program operations..........	173	9,774,000	158	9,354,000	158	9,354,000	158	9,943,000
Subtotal..................	621	56,285,000	555	53,865,000	555	53,865,000	555	55,453,000
Immunization:								
Grants........................	88	47,359,000	80	45,323,000	80	45,323,000	80	47,666,000
Program operations..........	128	8,235,000	117	7,744,000	117	7,744,000	117	8,346,000
Vaccine stockpile...........	--	4,000,000	--	3,828,000 /1	--	3,828,000 /1 /3	--	--
Subtotal..................	216	59,594,000	197	56,895,000	197	56,895,000	197	56,012,000
Infectious Diseases...........	753	106,698,000	713	39,944,000 /1	713	35,159,000 /1 /2	713	36,358,000
(AIDS)........................	(188)	(64,925,000)/6	(188)	(62,133,000)/6	(188)	(50,285,000)/6 /2	(188)	(45,409,000)/6
Chronic and Environmental Disease Prevention...........	489	30,425,000	446	29,065,000 /1	426	23,323,000 /1 /2	426	24,425,000
Occupational Safety and Health:								
Research......................	853	58,923,000	806	56,168,000 /1	806	56,168,000 /1	806	60,036,000
Training......................	--	8,760,000	--	8,383,000 /1	--	-- /1 /2	--	--
Subtotal..................	853	67,683,000	806	64,551,000	806	56,168,000	806	60,036,000
Epidemic Services.............	945	51,766,000 /7	863	49,561,000 /1 /7	863	49,561,000 /1 /4 /7	863	53,597,000 /7
Buildings & Facilities........	--	3,797,000	--	29,429,000	--	27,527,000 /2 /5	--	1,810,000
Program Management............	81	3,096,000	68	2,959,000 /1	68	2,959,000 /1	68	3,096,000
Total obligations...........	4,031	472,327,000	3,696	415,254,000	3,676	393,006,000	3,676	380,312,000

	1986 Appropriation		1986 Available after Sequestering		1986 Revised		1987	
	FTE	Amount	FTE	Amount	FTE	Amount	FTE	Amount
Offsetting collections.........	--	-466,000 /7	--	-447,000 /7	--	-447,000 /7	--	-466,000 /7
Unobligated balance, start of year................	--	--	--	-25,840,000	--	-25,840,000	--	--
Unobligated balance, end of year..................	--	--	--	--	--	--	--	--
Unobligated balance, lapsing......................	--	--	--	+471,000 /1	--	+471,000 /1	--	--
Total budget authority......	4,031	471,861,000	3,696	389,438,000	3,676	367,190,000	3,676	379,846,000
Reimbursable-Superfund......	101		101		101		101	
Reimbursable-Agent Orange...	55		55		55		55	
Reimbursable-Refugees.......	44		44		44		44	
Reimbursable-Other..........	166		138		138		138	
Trust Fund..................	1		1		1		1	
Total.....................	4,398		4,035		4,015		4,015	

/1 Reflects obligations withheld totaling $471,000 for the appropriation, as required by Section 515 of the Treasury-Postal Service Appropriation Act, 1986.

/2 Reflects portion of rescission totaling $34,096,000 for the appropriation.

/3 Includes $5,000 in unobligated balance carried forward from prior year.

/4 Includes $40,000 in unobligated balance carried forward from prior year.

/5 Includes $25,795,000 in unobligated balance carried forward from prior year.

/6 Funding for AIDS in 1987 in the amount of $45,800,000 is requested under the appropriation "Priority Disease Control and Research", Office of the Assistant Secretary for Health. The 1986 amounts shown here as non-add items have been excluded from 1985 and 1986 (except 1986 appropriation) to provide comparability to 1987.

/7 Includes user fee collections in Epidemic Services reflecting an offset to budget authority.

RESCISSIONS PROPOSED

Mr. **Natcher**. You are also proposing 1986 rescissions for CDC totaling $34,096,000, including six program terminations. The President just signed our 1986 bill in December, as you know. Why do you have all these rescissions just a few months later, Doctor?

Dr. **Mason**. Again, we are involved in the budget of the President where the Administrator believes that given current pressures for budgetary restraints, this is not the time to be increasing or funding new programs. Those items were involved in these rescissions.

Mr. **Natcher**. You would agree with us, wouldn't you, Doctor, that these programs are all worthy programs, good programs?

Dr. **Mason**. Yes. I think we are having to choose not between good and bad but between high priorities and lower priorities.

Mr. **Natcher**. This then would be just a matter of going through and eliminating the Congressional add-ons? Is that what took place, Doctor?

Dr. **Mason**. Yes. The rescissions are basically Congressional add-ons.

Mr. **Natcher**. Just taking them out.

Mr. **Williams**. Mr. Chairman, if I might make a comment in this context. Since the appropriation was originally signed, passage of Gramm-Rudman-Hollings legislation did set out very specific deficit reduction targets both for 1986 and 1987 and future years. These rescissions in 1986 do help reach those clear targets in 1987 so that by reducing some spending in 1986, it helps to meet future targets. That's another reason why these were done.

Mr. **Natcher**. Are there any employment reductions associated with the rescissions that are before us?

Dr. **Mason**. There are FTE's associated with some of the rescissions.

Mr. **Natcher**. How many would you say?

Dr. **Mason**. About twenty.

Mr. **Natcher**. At this point in the record, we will insert your rescission justification.

[Information to be furnished follows:]

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR DISEASE CONTROL

Disease Control, Research, and Training

1986 Rescission Budget	Page
Appropriation language	111
Amounts available for obligation	112
Summary of changes	113
Budget authority by activity	114
Budget authority by object	115
Justification:	
Narrative:	
1. Prevention Centers	116
2. Infectious Diseases	117
3. Chronic and Environmental Disease Prevention	120
4. Occupational Safety and Health	123
5. Buildings and Facilities	123

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR DISEASE CONTROL

Disease Control, Research, and Training

Appropriation Language

Of the funds made available under this head in Public Law 99-178, $34,096,000 are rescinded.

CENTERS FOR DISEASE CONTROL

Disease Control

Amounts Available for Obligation /1

1986 Appropriation	$471,861,000 /2
1986 Sequester order	-20,290,000
Proposed rescission	-34,096,000
Subtotal, adjusted appropriation	417,475,000
Receipts and reimbursements from: Non-federal sources: User fees	447,000
Unobligated balance, start of year	25,840,000
Unobligated balance, lapsing	-471,000
Total, obligations	443,291,000

/1 Excludes reimbursements of $30,000,000.
/2 Includes $10,000,000 derived from unobligated balances provided under P.L. 94-266 for national influenza immunizations.

Summary of Changes

1986 Estimate	$471,861,000
1986 Sequester order	20,290,000
1986 Estimate after sequestering	451,571,000
1986 Revised estimate	417,475,000
Net change	-34,096,000

	1986 base	Change from base
Decreases:		
Program:		
1. Prevention centers	$1,436,000	-$1,436,000
2. Infectious diseases		
AIDS -		
24-hour Hotline	1,914,000	-1,914,000
Alternate test sites	9,934,000	-9,934,000
TB grants	4,785,000	-4,785,000
3. Chronic and environmental disease prevention -		
Diabetes State projects	4,785,000	-4,785,000
Designer drugs study	957,000	-957,000
4. Occupational safety and health - Training grants	8,383,000	-8,383,000
5. Buildings and facilities - Equipment for virology laboratory	1,902,000	-1,902,000
Total decreases		-34,096,000
Net change		-34,096,000

CENTERS FOR DISEASE CONTROL

Disease Control

Budget Authority by Activity

	1986 Appropriation	1986 after Sequestering	1986 Revised Estimate	1986 Proposed Rescission
Prevention centers............	$1,500,000	$1,436,000	-	-$1,436,000
Infectious diseases:				
Less AIDS..................	64,925,000	62,133,000	$50,285,000	-11,848,000
Infectious dis. comparable.	41,773,000	39,977,000	35,192,000	-4,785,000
Subtotal.................	106,698,000	102,110,000	85,477,000	-16,633,000
Chronic and environmental disease prevention..........	30,425,000	29,117,000	23,375,000	-5,742,000
Occupational safety and health:				
Research....................	58,923,000	56,389,000	56,389,000	-
Grants....................	6,501,000	6,221,000	6,221,000	-
Program operations.......	52,422,000	50,168,000	50,168,000	-
Training grants............	8,760,000	8,383,000	-	-8,383,000
Subtotal...............	67,683,000	64,772,000	56,389,000	-8,383,000
Buildings & facilities.......	3,797,000	3,634,000	1,732,000	-1,902,000
All other....................	261,758,000	250,502,000	250,502,000	-
Total......................	471,861,000	451,571,000	417,475,000	-34,096,000

Budget Authority by Object

	1986 Appropriation	1986 after Sequestering	1986 Revised Estimate	1986 Proposed Rescission
Personnel compensation:				
Permanent positions............	$104,728,000	$100,225,000	$99,556,000	-$669,000
Positions other than permanent.	7,368,000	7,051,000	7,051,000	-
Other personnel compensation...	4,097,000	3,921,000	3,921,000	-
Subtotal, personnel comp.....	116,193,000	111,197,000	110,528,000	-669,000
Personnel benefits...............	23,269,000	22,268,000	22,148,000	-120,000
Travel & transportation of persons	6,400,000	6,125,000	6,078,000	-47,000
Transportation of things.........	1,655,000	1,584,000	1,584,000	-
Rent, communications & utilities.	11,186,000	10,643,000	10,638,000	-5,000
Standard level user charges......	1,443,000	1,443,000	1,443,000	-
Printing and reproduction........	1,288,000	1,233,000	1,231,000	-2,000
Other services...................	16,694,000	15,976,000	15,926,000	-50,000
Project contracts..............	11,079,000	10,602,000	8,688,000	-1,914,000
Supplies and materials...........	33,217,000	31,789,000	31,787,000	-2,000
Equipment........................	15,477,000	14,811,000	12,909,000	-1,902,000
Lands and structures.............	701,000	671,000	671,000	-
Grants, subsidies & contributions	233,259,000	223,229,000	193,844,000	-29,385,000
Total, by object..............	471,861,000	451,571,000	417,475,000	-34,096,000

Centers for Disease Control

Disease Control

	1986 Appropriation	1986 after Sequestering	1986 Revised Estimate	Proposed Rescission
1. Prevention centers	$1,500,000	$1,436,000	---	$1,436,000

Purpose and Method of Operations

Prevention centers would be funded to conduct research and demonstration projects on health promotion and disease prevention techniques.

Rationale for the Proposed Rescission

A rescission of $1,436,000 is proposed as part of the President's overall budget reform plan to curtail Federal Government spending.

Because of the overriding need for Federal fiscal constraint, it is difficult to justify starting new programs, such as prevention centers, at this time. CDC currently spends about $1 million a year on cooperative agreements and contracts for similar research and demonstration projects on health promotion and disease prevention. In addition, over $1.2 billion are spent each year by other Federal biomedical research agencies on prevention research activities.

Centers for Disease Control

Disease Control

	1986 Appropriation	1986 after Sequestering	1986 Revised Estimate	Proposed Rescission
2. Infectious diseases:				
AIDS:				
Hot line..	$2,000,000	$1,914,000	---	-$1,914,000
Alternate test sites	$10,380,000	$9,934,000	---	-$9,934,000
TB grants..	$5,000,000	$4,785,000	---	-$4,785,000

AIDS Hotline

Purpose and Method of Operation

The Centers for Disease Control would establish, maintain, and operate under contract a 24-hour hotline which would permit calls to be made without charge to the caller, and would provide general information concerning Acquired Immune Deficiency Syndrome (AIDS) and information concerning medical services and housing facilities for individuals with such syndrome, and refer such individuals to counseling services.

Rationale for the Proposed Rescission

A rescission of $1,914,000 is proposed as part of the President's overall budget reform plan to curtail Federal Government spending.

The Centers for Disease Control will continue to operate the national AIDS hotline that is now in existence, which provides updated AIDS information and referrals to local agencies and health departments for additional information and counseling. Many of the more affected communities (e.g., New York City, San Francisco, Chicago, Miami, New Orleans, Honolulu) are also supporting their own AIDS hotlines. Hotlines work best when they are affiliated with local service providers and can directly refer those in need to local service capacities. In addition, the Congress has provided over $20 million in 1986 to start risk reduction/health education programs in each of the States, which should result in more informed people and reduce the need to expand the current national AIDS hotline.

Alternate Sites

Purpose and Method of Operation

To protect the Nation's blood supply, funds for start-up of AIDS alternate test sites to blood donation stations were provided to States which applied. These resources were used by States to test persons for the presence of HTLV-III virus, the causative agent for AIDS in blood samples at sites other than blood donation stations.

Rationale for the Proposed Rescission

A rescission of $9,934,000 is proposed as part of the President's overall budget reform plan to curtail Federal Government spending.

Funds provided in FY 1985 for the AIDS alternate test sites will not be continued. These funds were provided to State and local communities explicitly with the intent to cover start-up costs and accelerate the creation of alternative AIDS blood testing sites, after which the States and local communities were to continue ongoing support. CDC will continue its intensive efforts to develop new blood tests and continue to provide technical assistance to States and localities.

Tuberculosis Grants

Purpose and Method of Operation

Provides grants to States and localities with relatively high-incidence of tuberculosis (TB) for implementation of TB control and prevention strategies. Funds are used primarily to hire outreach workers to enhance compliance with outpatient drug therapy among persons with TB.

Rationale for Proposed Rescission

A rescission of $4,785,000 is proposed as part of the President's overall budget reform plan to curtail Federal Government spending.

Alternative funds from the Preventive Health and Health Services Block Grants (funded at $87 million in 1986) and the Refugee Preventive Health Program (funded at $8 million in 1986) are available for this purpose. CDC will continue to provide consultation, training, disease surveillance, operational research, and other technical assistance to the States in TB control and prevention.

Centers for Disease Control

Disease Control

	1986 Appropriation	1986 after Sequestering	1986 Revised Estimate	Proposed Rescission
3. Chronic and environmental disease prevention:				
Diabetes state projects ...	$5,000,000	$4,785,000	---	$4,785,000
Designer drugs	$1,000,000	$957,000	---	$957,000

Diabetes State Projects

Purpose and Method of Operation

Since 1977, CDC has provided funds for State health departments to establish diabetes control programs. The purpose of the projects was to demonstrate that efforts to control and prevent complications resulting from the onset of diabetes could be cost-effective to the States. These programs have established organizational networks for translation, coordination, communications, and other capacity-building activities; conducted special studies to identify problems and factors contributing to excess diabetes morbidity; and implemented and evaluated interventions in a variety of community settings. Programmatic linkages between diabetes, hypertension, maternal and child health, and other chronic disease programs have been increased. Several project States have demonstrated that education programs lead to cost savings from decreased hospitalizations. Other non-project States have either started their own diabetes control programs or secured third-party reimbursement for patient education.

Rationale for the Proposed Rescission

A rescission of $4,785,000 and 20 FTE is proposed as part of the President's overall budget reform plan to curtail Federal Government spending.

A rescission is proposed to discontinue the State diabetes projects. Current State diabetes control projects have had Federal developmental support for 6 to 8 years ($5 million in 1985). Now these demonstration projects should be continued by the States or other third-party payment sources which have also benefitted financially from their success. Sufficient knowledge and experience is available, and States can use alternative funding sources to continue these activities. CDC will continue to provide technical assistance to States seeking to implement diabetes control programs.

Designer Drugs Study

Purpose and Method of Operation

Research would be conducted on the prevalence of designer or synthetic drug use and the clinical effects of these drugs over time. Scientists would follow the more than 400 young people who CDC has identified as having Parkinson-type symptoms from a bad batch of these drugs and identify more such cases. Studies of users taking the fentanyl series of these drugs would also be initiated.

Rationale for Proposed Rescission

A rescission of $957,000 is proposed as part of the President's overall budget reform plan to curtail Federal Government spending. These funds were added to the budget by Congress in excess of the Administration's request and the program's needs. Determinations on the need for long-term epidemiological studies of designer drug use should be considered in the context of all other drug abuse research and should compete through the peer-review process for available funds.

Centers for Disease Control

Disease Control

	1986 Appropriation	1986 after Sequestering	1986 Revised Estimate	Proposed Rescission
4. Occupational safety and health: Training ...	$8,760,000	$8,383,000	---	-$8,383,000

Purpose and Method of Operation

This program has provided limited Federal support to allow major universities that were institutionally committed to occupational training, to expand to meet increased student and employee interest in the occupational field.

The development of Occupational Safety and Health Educational Resource Centers (ERC) has demonstrated the effectiveness of providing both full time and continuing education—training occupational safety and health professionals, specialists, and technicians, as well as becoming a resource to management and labor for the region in which they are located.

Rationale for the Proposed Rescission

A rescission of $8,383,000 is proposed as part of the President's overall budget reform plan to curtail Federal Government spending.

The Educational Resource Centers (ERC) have been federally funded for the past eight years. The proposed rescission represents the successful completion of the Federal ERC program of expanding university programs to meet increased student, business, and public health interest in the occupational health field, with a proposed shift toward State and private sector financing. The principal users of those individuals trained (industry and State governments) should now increase their financial support to maintain these centers. Nine of the existing 15 university-based ERC's have had Federal development support for eight years. They should now be able to sustain and continue their academic and continuing education training programs.

Centers for Disease Control

Disease Control

	1986 Appropriation	1986 after Sequestering	1986 Revised Estimate	Proposed Rescission
5. Buildings and facilities ..	$3,797,000	$3,634,000	$1,732,000	-$1,902,000

Purpose and Method of Operation

The CDC's Facility Planning Board has the responsibility to: (1) assess the adequacy of CDC facilities and equipment to do its job and to assure that all facilities, particularly laboratories, are safe for both workers and the community; (2) protect the facility investment of the Centers for Disease Control by preventing deterioration and by upgrading, where necessary, to ensure that facilities meet current required standards; and (3) meet the Centers' responsibility to reduce or conserve the energy necessary to operate the Centers' facilities and equipment.

To meet these goals, the Facility Planning Board continuously monitors the need for repair and improvement of the Centers' facilities. Priority rankings are assigned to each required project to ensure the accomplishment of those projects which are mandatory to protect the facility investment of the Centers and ensure that quality facilities are available to the programs of the Centers. The board also determines the need for equipment for new laboratories and other equipment.

Rationale for the Proposed Rescission

A rescission of $1,902,000 is proposed as part of the President's overall budget reform plan to curtail Federal government spending.

The proposed funding level will provide for the repairs and improvement projects necessary to protect CDC's facilities, but does not provide funds to purchase non-fixed scientific equipment for the virology laboratory now under construction. The laboratory will be equipped in phases.

TUBERCULOSIS

Mr. **Natcher**. How many tuberculosis cases were reported in 1985, Dr. Mason?

Dr. **Mason**. In 1985, we continued to show a decrease in reported tuberculosis cases. We are about two percent down from the previous year. The provisional total of 21,801 cases were reported in 1985.

Mr. **Natcher**. Dr. Mason, in light of that number of cases, is it wise to eliminate the $5 million that we have in for the tuberculosis program?

Dr. **Mason**. These grants have been given to the states over a number of years. The Administration feels that with the Preventive Health Services block grant and refugee money, that states ought to be able to pick up or continue these activities using either these Federal funds or their own funding moneys.

Mr. **Natcher**. Do you have any evidence that the states are spending a significant amount of their block grant funds for tuberculosis control?

Dr. **Mason**. Some of the states are spending money for tuberculosis control.

Mr. **Natcher**. Mr. Early, I yield to you.

Mr. **Early**. Thank you. Dr. Mason, you just told Mr. Natcher about the decline in tuberculosis. I understand that in 1985 Massachusetts had an increase of 22 percent and nine deaths. Is that correct?

Dr. **Mason**. In tuberculosis cases? I don't know. I was giving national figures. I do not have specific data for Massachusetts in front of me. We can get that.

Mr. **Early**. I understand that during 1985, a total of 459 cases of tuberculosis and nine deaths were confirmed state-wide, an increase of 22 percent over the number reported in 1984. Wouldn't that frighten you?

Dr. **Mason**. Yes. If I might turn to Dr. Lane; do you have any specific information?

Dr. **Lane**. Sir, I don't have the data with me. I believe those are essentially the right numbers. In fact, I think the number of deaths is slightly higher.

Mr. **Early**. To the Chairman's question, Dr. Mason, you suggested the national figure was a trend. I think it probably would have been a little better for us if we knew the states where it is increasing. That is a threatening thing in Massachusetts.

No way do I want to take away from CDC, but I thought the Administration made a major mistake a couple of years ago in transferring as much money as they did to CDC, not that CDC couldn't use the money and not that you are not very valuable. You are absolutely necessary. But don't take it away from some others that are into vaccines and into discovery. I know you have a tough budget to defend.

DIVERSION OF RESOURCES TO AIDS PROGRAM

Last year we had a hearing. I think you were asked "do you think that other programs are suffering at the expense of what we are doing with regard to AIDS?" At that time, Dr. Hopkins replied

"I wouldn't say our programs are suffering unduly. We have worked very carefully to protect those other programs from diversion of people and resources to work on the AIDS problem. We have devoted to the AIDS problem those moneys that have been provided for it."

However, Dr. Mason, and please confirm or deny this, I understand that by the end of 1985, as much of 30 percent of the sexually transmitted disease control program and 45 percent of the staff were transferred to AIDS. Is that accurate?

Dr. MASON. We have undoubtedly shared people between sexually transmitted disease and AIDS for a number of reasons. First of all, if we want to get control of this problem, we are going to have to send in our most seasoned and able troops. The people that are really geared up to the control of a disease like AIDS, which is transmitted by IV drug abuse and through sexual intercourse, are some of our best STD people, and we have used them in this process. That is because they are the best experts.

You are right. There has been some diversion of resources from STD into the AIDS battle. I think that is wise because of the enormity of the problem.

Mr. EARLY. That is the independence and flexibility I want you to have, to decide who goes where. I think you pick up the slack. I am told that—I was startled by this. I understand that gonorrhea cases increased in 1985 for the first time in five years. I understand it increased almost 6.8 percent. According to your own explanation of this increase, it can be partly attributed to a shift of priority to AIDS.

Isn't gonorrhea still a tremendous threat?

Dr. MASON. Gonorrhea is still a tremendous threat. We have to agree with that. We have made some shifts. That may partially account for some of the increases we have seen in gonorrhea in comparing 1985 with 1984.

Mr. EARLY. I can only speak for one member, Dr. Mason. I want to address AIDS but I want to direct AIDS honestly. I don't want to take it from Peter to give to AIDS. I just think that is wrong. I don't think the Committee was ever informed of any transfers, Doctor. Were they?

Dr. MASON. I believe you have given us the flexibility in a number of areas to move people where an emergency exists and where we have the talented people with experience who can play a significant role. That's exactly what we have done. We did that for toxic shock and for Legionnaire's disease. One has to do that.

Mr. EARLY. I want you to do that. I just want to see you pick up some additional people so that those particular problems are not just left up in the air because they are not politically sexy. They are every bit as important as any I have ever seen.

Dr. MASON. Dr. Hopkins coordinates our AIDS effort at CDC.

Dr. HOPKINS. I would just add one small point of emphasis. Unlike some of the other transfers we have had to make in years past, the STD transfers for AIDS have also benefitted STD efforts also some of the actions we are recommending to prevent transmission of AIDS, namely reducing the number of sexual partners, using condoms and things like that, also impact on the other traditional sexually transmitted diseases.

While we are having them work on AIDS, there is also still some indirect benefit to the traditional STD programs.

SYPHILIS AND GONORRHEA TRANSMISSION

Mr. **Early**. Doctor, do we have anything to suggest that syphilis and gonorrhea, is associated with the use of needles, as there is with regard to AIDS?

Dr. **Hopkins**. No. Those diseases are not associated with use of needles. Syphilis can be transmitted by blood transfusions and the blood banks have in place testing for syphilis as they do for the HTLV-III virus now.

AIDS VACCINE DEVELOPMENT

Mr. **Early**. Dr. Mason, in your opening chart, you showed us that the number of cases of AIDS reported in one year has doubled.

Dr. **Mason**. That's right.

Mr. **Early**. I think you said the number of deaths has doubled. That, to me, is frightening. That is really alarming, as I have read suggestions that this virus might lay dormant for five years. I don't want to frighten everyone. The other day, the testimony in one of the hearings suggested that we weren't going to have a vaccine for three years. I think we should be spending an awful lot of money to speed that up.

Dr. **Mason**. I can't specifically speak on the vaccine development because that isn't CDC's prime role. We see ourselves as playing a very strong and important supportive role. I couldn't agree more with you that in the area of vaccine development and chemotherapy development, we ought to do everything possible. At the same time, I see CDC's role as at the community level.

We should try to change behavior, and I am talking about the behavior of IV drug abusers, and the behavior of people who are sexually active with frequent partners, anonymous partners. While we are waiting for a vaccine and doing everything we can to get that vaccine, we have to influence the behavior of people.

Mr. **Early**. I agree. That is why I have an awful lot of trouble with the recommended rescission, Doctor.

CHLAMYDIA

In chlamydia, I thought I had been hearing for years that it was a woman's disease. Dr. Fauci told me it affects both male and female.

Dr. **Mason**. It is a venereal disease, sexually transmitted disease. The male transmits it to the female and the female back to the male. Unfortunately, it is the female that has the very alarming permanent sequela, pelvic inflammatory disease. The real effect of chlamydia is painful in the male but the woman ends up with an abscess in her pelvis, or sterility, or her newborn may be affected and have eye problems that could lead to blindness or pneumonia as the infant is passing through the birth canal and becomes infected with the chlamydia.

Mr. **Early**. Thank you. Doctor.

This Committee, for the last few years, has increased your funding in that area. Have we seen a decline in the cases reported? What is the status of that?

Dr. **Mason**. May I ask Dr. Lane, who is responsible for STD control, to report on that?

Dr. **Lane**. Sir, not all states yet report chlamydia. Because it is difficult to diagnose with traditional diagnostic techniques, the number of cases diagnosed in the laboratory sense and reported are only a fraction of those that occur. We don't have good data. The limited data that we have show that no, it is not yet decreasing.

SEXUALLY TRANSMITTED DISEASES INCIDENCE

Mr. **Early**. Dr. Lane, how about any of the other sexually transmitted diseases? How many of them are declining?

Dr. **Lane**. We do have a substantial decline in primary and secondary syphilis, as Dr. Mason has already mentioned. Gonorrhea varies in different parts of the country. There are substantial declines in many of those communities that have a lot of AIDS and where sexual behavior is changing substantially, perhaps because of fear of AIDS.

In general, most of the viral sexually transmitted diseases, for which we have no vaccine or chemotherapy, are not declining. They are steadily increasing. The other major bacterial diseases, mainly chlamydia, as you mentioned, is still apparently increasing.

HERPES

Mr. **Early**. Dr. Mason, we still don't have anything to treat, or identify the causes of herpes?

Dr. **Mason**. We have a drug called acyclovir, which can be given, which shortens the symptoms and the recurrences but it does not eradicate the disease in either the male or female.

Mr. **Early**. Are we doing enough to improve on this?

Dr. **Mason**. Here again our prime responsibility is to work at the community level to control transmission by tracking and following up. We are trying to be very supportive in a cooperative relationship between NIH and academia, to work on chemotherapeutics and other ways of getting fundamentally to the core of the problem and on how to develop a vaccine or how to, in some way, cure it through therapy. Again, we have got to change behavior before we are going to see a major shift in the occurrence of these sexually transmitted diseases.

Mr. **Early**. You have to have the tools to do that. You are not going to do it with this budget, in my opinion.

CHANCROID

A final question; in Massachusetts this year we had an outbreak of a disease called chancroid.

Dr. **Mason**. I am going to ask our expert to report on chancroid.

Dr. **Lane**. Chancroid is a bacterial sexually transmitted disease relatively uncommon in this country. There have been small local outbreaks in southern California, in Florida and Massachusetts. It is painful and uncomfortable. It usually does not have major long term sequela.

Mr. **Early**. Dr. Lane, I thought that its origin was Africa, Southeast Africa. We have had 53 cases reported from January to September as compared to two cases the entire previous year. Would you be familiar with the problem?

Dr. **Lane**. I am generally familiar, not with all the details. You are right, sir. It is a very common disease in many of the Third World countries. In this country, there are always a few cases each year and occasionally an outbreak, sometimes because it is not recognized by clinicians working in STD clinics and a few times because the antibiotics that are frequently used prove ineffective and we have to shift to other antibiotics. In general, we have been able to control outbreaks to keep them from getting to be hundreds of cases.

Mr. **Early**. Thank you, Mr. Chairman.

Mr. **Natcher**. Mr. Dwyer.

AIDS TRANSMISSION BY INTRAVENOUS DRUG USE

Mr. **Dwyer**. Thank you, Mr. Chairman. Good morning, Doctor. Going back to AIDS for the moment, the incidence in New Jersey is relatively high and our State Health Department indicates that most of the victims have contracted the disease as a result of intravenous drug use.

What have your studies been able to tell you about this particular means of transmission?

Dr. **Mason**. You are absolutely right, that IV drug abuse is undoubtedly the second leading cause of AIDS transmission. The first is sexual transmission, particularly in homosexual and bisexual males, with IV drug abuse occurring second. I am quoting national trends. If we begin to look at the community level, then in cities like New York City and some of your cities in New Jersey, there are relatively more cases associated with IV drug abuse and sharing needles.

Mr. **Dwyer**. How are you working with state and local communities to reach this particular high risk population, the drug users?

Dr. **Mason**. I would like to call upon Dr. Hopkins to outline that.

Dr. **Hopkins**. I would mention that we have several studies underway to try to understand the epidemiology of this problem in IV drug abusers; and some of them in collaboration with Monte Fiore Hospital in New York, for example. We also work very closely with one of our sister agencies of the Public Health Service, the National Institute of Drug Abuse of the Alcohol, Drug Abuse and Mental Health Administration.

We think that in that population of people who, by the very nature of their IV drug abuse, might be said to have less instinct for self preservation than many others, it is important to try to put forth two main messages. One is the additional danger they are putting themselves by injecting themselves with IV drugs, and that they need to take care to try to protect themselves from AIDS; but even more fundamentally than that, that the IV drug abuse itself is putting them at risk of death.

So we are, with the Alcohol, Drug Abuse and Mental Health Administration, trying to promote a strategy of doing everything we can generally to reduce IV drug abuse, with or without AIDS, but also in those communities where there is AIDS, putting a special push on because of the AIDS problem.

Dr. Mason. I would like to just add that this current issue of the Morbidity and Mortality Weekly Report, dated March 14th, contains within it additional recommendations to reduce sexual and drug abuse related transmission of AIDS. This is the result of consultants and experts inside and outside of the Public Health Service, and has now been distributed through the MMWR, which focuses on some more specific actions that can be taken to stop the spread of this disease through IV drug abuse.

Mr. Dwyer. Do you monitor the drug treatment centers to see if they are doing enough to educate the people about the use or the dangers of intravenous use of drugs and its relation to AIDS?

Dr. Hopkins. We have some collaborative projects there, and I would say the amount that people are doing in local areas varies according to the area. The greater New York-New Jersey area, particularly northern New Jersey, is doing more than many other areas to educate people in IV drug abuse centers.

In the guidelines we issued last week, we are now recommending that the serologic test for AIDS be routinely offered to people being seen in drug abuse centers, again by way of giving them some additional specific reason to reduce their IV drug abuse and protect themselves against this problem.

COOPERATION WITH DRUG ENFORCEMENT ADMINISTRATION

Mr. Dwyer. You mentioned the DEA before. How closely do you work with the Drug Enforcement Administration? I'm thinking of the successful campaign that actually reduced cigarette smoking in this country by emphasizing its link to cancer. Have you people, in conjunction with the DEA or in cooperation with them, come up with any studies that indicate the serious physical effects due to the use of cocaine? When you read the increase of this drug in our population, it is extremely disturbing. It just seems that there has got to be some type of a program that will convince the American people that it is a slow form of death.

Is there any type of a project like that in mind or being put together?

Dr. Mason. The answer to that is yes. The coordinating focus is the Domestic Policy Council of the President, where DEA, Public Health Service, Department of Health and Human Services, and specifically within it, ADAMHA. CDC to a lesser extent, are getting together on demand reduction activities. We do indeed see that AIDS is to drug abuse like lung cancer is to tobacco.

Unfortunately, a fear of dying of a disease is not as powerful a tool as we wish it were because people see that death occurring sometime in the distant future. The closer the linkage one can make, I think the more powerful argument one can make for encouraging people either not to start abusing drugs or to stop if they are already doing that.

Mr. **Dwyer**. Well, when you raise the question with the DEA and the other enforcement agencies of the government of the cocaine problem and its adverse effects on society, it is a frustrating problem in that we cannot seem to interdict all the drugs that are coming in from foreign countries. But the foreign countries, when we seek their cooperation, say we are not the problem. They say that our consumers are the problem; the American population is the problem.

So it just seems to me that there has got to be some strong effort to educate the public about its devastating effects.

Dr. **Mason**. We agree.

Mr. **Dwyer**. In my questioning of the DEA at another subcommittee, they didn't seem to think there was any program being put together, and this I found troublesome.

EDUCATIONAL RESOURCE CENTERS

Let me change the subject, if I might: the National Institute for Occupational Safety and Health, NIOSH. The Chairman already spoke to the proposed rescission, and of course it is going to have an effect on these Educational Resource Centers.

If I might, Doctor, in your professional judgment, is this graduate training necessary to meet the demand for trained occupational health and safety professionals?

Dr. **Mason**. If I might, I would call upon Dr. Millar, who is the Director of NIOSH, to respond to your question.

Dr. **Millar**. Thank you.

As you know, Mr. Dwyer, the administration has for several years not requested funding for the ERC program, so the administration position is that although this is a very valuable, worthwhile program, that the time has come for this program to be supported by the private sector, and principally those people in industry and in organized labor who use the graduates most frequently.

In response to the question, it is clear that if ERCs were to all close down, there would be a very significant impact on the production of trained professionals for occupational safety and health.

POLIO VACCINE

Mr. **Dwyer**. If I might, on the news this morning, quite by accident, there was a release about the polio vaccine and the increase of polio cases, and the fact that there is a difference between the two types of vaccine. If I heard the report correctly, there is no risk of polio with the——

Dr. **Mason**. With the inactivated vaccine.

Mr. **Dwyer**. Yes, which is the Salk vaccine, I guess, and there is some risk with the active vaccine, the oral or Sabine vaccine.

Dr. **Mason**. The risk with the oral vaccine is about one case per 2.5 million doses.

Mr. **Dwyer**. Yes. They made that point, I think, abundantly clear, but they also showed a picture of this 2 or 3-year old child who was a hopeless cripple and will be this way for the rest of her life.

Now, does your center have an opinion on this? I am sure you are aware of it.

Dr. Mason. Very much aware of it. We have followed this very, very carefully. Because of the close follow-up, we have been aware that those cases that are occurring in the United States are vaccine-related cases, and of course, that gives us a great deal of alarm and concern. In fact, we were concerned enough that on several occasions we have convened what is called the Advisory Committee for Immunization Practices, which is a group of experts in the field of immunization.

In addition to that group, we have asked the Institute of Medicine to look at this and give recommendations. In the last meeting of the Immunization Advisory Practices Committee, they looked at these cases, and their problems, and still recommended that the philosophy of the United States should be to use the oral polio vaccine, and I will tell you why.

It is very possible that we would not have those five vaccine-related cases if we used inactivated vaccine, but the feeling is that we would continue to have cases of wild polio if we were using just the inactivated. I think one has to weigh, put on your balance and your scales, where can you do the greatest amount of good? Is it better to have five vaccine-associated cases and no wild cases in the nation, or to have 50 or 100 wild polio cases because the inactivated vaccine did not either adequately immunize or did not interrupt as well the chain of movement of the wild virus through the population? It is that that we are weighing.

POLIO VACCINE OPTIONS

Mr. Dwyer. Let me ask you this. Why, then, isn't the parents given the option of one or the other? Is there an explanation made by a treating doctor or an administering doctor so that the parent can make the judgment?

Dr. Mason. Dr. Lane, would you like to address the procedure?

Dr. Lane. Yes, sir. In all publicly-supported clinics where vaccine is supplied by the grants coming from the Centers for Disease Control and state agencies, the parent reads a formal written statement and signs it which describes the risks and benefits of the oral polio versus the inactivated polio. In the overwhelming majority of cases, they have elected to use the oral polio vaccine.

May I say one little thing, sir? You mentioned in your question to Dr. Mason that you came away from that program with the view that polio cases were increasing, and the answer is they are not, they are decreasing. What has happened, though, is all the cases that do exist right now are vaccine associated.

Mr. Dwyer. No, I didn't come away with the idea that it was increasing. I really thought, like most lay people in this country, that it was completely wiped out and would stay in that situation as long as the vaccine was administered. But what I did not know was whether parents are provided enough information to make an educated decision when they actually have the vaccine administered to their child.

The question that is begged now is, if your wife were taking your son or daughter to the doctor tomorrow for the vaccine, what would you have administered?

Dr. **Lane**. I have a newly-adopted little daughter and I have had her immunized with oral polio vaccine, and I certainly wouldn't give her the inactivated polio vaccine. Again, when the risks and benefits of the two vaccines are explained in layman's language that has been approved for that specific use in public clinics throughout this land and used for over a decade, American parents continue to opt for oral polio vaccine. As Dr. Mason pointed out, the experts on both the Advisory Committee on Immunization Practices and the Institute of Medicine and the Academy of Pediatrics still recommend oral polio vaccine.

Mr. **Dwyer**. Then let me break down, if I might, the layman's logic. If I choose the Salk vaccine for my son or daughter, I don't expose my son or daughter to any risk.

Dr. **Lane**. No, sir, I don't think that is true. As far as we know, there is no risk of getting polio-like illness from inactivated polio vaccine, but we don't have the kind of substantial use of that vaccine to be able to calculate whether there is a risk of some side effect like, for instance, Guillian Barre or some other kind of disease, at the rate of something like one in 2.5 million, which as Dr. Mason pointed out is the risk of acquiring a polio-like illness from the oral polio.

So we don't have data to show that with millions and millions of doses, the IPV is definitely safer than the OPV.

Mr. **Dwyer**. But you have no reported cases of polio from the Salk vaccine.

Dr. **Lane**. Yes, sir, that is correct.

Dr. **Mason**. But although you have no polio with the inactivated vaccine, the likelihood of having other problems, like Guillian Barre disease, at a risk of one in every 2.5 million is very high. I think it is important to recognize that when you give the oral vaccine, you immunize the bowel, the gut, so that individual no longer sheds virus and transmits virus. When you give the inactivated vaccine, the person may be immune but they may pass wild polio on at the same time to an unimmunized child.

So you are absolutely right that on an individual case, the risk of getting polio from the oral vaccine, although it is so exquisitely small, it is greater than with the inactivated vaccine. But, the risk of an adverse effect occurring to that child of any kind, not polio, but any adverse effect, is no greater with one than with the other. The protection of society is much greater with the oral than the inactivated. When you put all this together, that is why all of my children have had oral and why I would recommend it to others.

The risk of death or paralysis from oral vaccine is about one-one thousandth the risk of getting hurt in driving to the doctor's office to get the vaccine. It is infinetessimally small.

Mr. **Dwyer**. Just one more question. I see that my time has been used up. You mentioned that people are informed when they go to public-supported clinics. Isn't the largest amount of vaccine administered in doctors' offices?

Dr. **Lane**. No, sir. It is about exactly 50-50 in this country. It varies from state to state. In some states, particularly with poorer populations, it is overwhelmingly more in the public sector versus private sector. I should say that the Academy of Pediatrics and the Academy of Family Practitioners also exhort their members to give analogous forms, and we have made the same written forms available to private physicians when they requested them, either directly through their own medical societies or through state health departments.

Increasingly, it is our understanding that private physicians are using the same kind of informed consent procedures.

Mr. **Dwyer**. Thank you.

Thank you, Mr. Chairman.

DESIGNER DRUG STUDIES

Mr. **Natcher**. Dr. Mason, assuming the rescission that is now before the committee is not approved, how would you plan to spend the $957,000 remaining for studies of designer drug use?

Dr. **Mason**. As you know, we have had now reported cases of serious adverse effects associated with designer drugs in California, Michigan, Texas, and Florida. The purpose of the $1 million provided was to do a number of things: first, to locate, interview, follow up, and examine persons exposed and not exposed to these analogs of meperidine; second, to make available clinical toxicology and forensic laboratory reference services; and third to create a working group to develop guidelines for assessing exposure to these drugs, evaluating related compounds, and for developing a national program to do something about it by intervening, and designing a program to eliminate them.

This would all be done collaboratively with ADAMHA, the National Institute of Drug Abuse, CDC, other Federal agencies, and academic institutions. All of these are going to have to be brought together to work on it. Some of these things would be done.

PREVENTION CENTERS

Mr. **Natcher**. What are your plans, Dr. Mason, for spending the $1.4 million appropriated for prevention centers? Tell us where these centers are to be located.

Dr. **Mason**. As you know, the money was developed with the concept that there ought to be one or more multiple centers in the United States which would have the capacity to apply and do research demonstration with regard to all of the interventions that are available to prevent disease. We would have a review panel, which in an unbiased way, would look at individuals who submitted an application. We couldn't say until we receive the applications and complete the review process where they would be located.

We would hope that there would be some geographic representation. We would hope that specific minority groups might be appropriately represented in those applications. We would want to see that all of the prevention centers were not concentrating on the same thing, but we were getting breadth and width in terms of what they were accomplishing.

Mr. **Natcher**. The location of the centers has not been agreed upon?

Dr. **Mason**. We have taken all the necessary steps to prepare for the implementation of the prevention program, but we haven't sent out a request for application. We would have to receive the applications, have them reviewed by a peer panel or a scientific panel that would look at the merits of each, and award them based on their merits.

Mr. NATCHER. That hasn't been done up to this time?

Dr. MASON. No.

AIDS APPROPRIATED FUNDS

Mr. NATCHER. How much was appropriated for AIDS activities in CDC for 1986, Dr. Mason?

Dr. MASON. In 1986 our money available for AIDS is $50.285 million.

Mr. NATCHER. In the original appropriation, now, wasn't that about $65 million.

Dr. MASON. With the materials that are scheduled for rescission and things like that.

Mr. NATCHER. And that amount would be how much?

Dr. MASON. $64.925 million.

Mr. NATCHER. How much was sequestered under Gramm-Rudman of that amount?

Dr. MASON. That would be about 4.3 percent of that amount. I think it comes to about $2.8 million.

Mr. NATCHER. The administration proposes to consolidate all AIDS funding in one account for 1987 under the Assistant Secretary for Health. Doctor, is this a good idea?

Dr. MASON. We are not opposed in any way to that idea. We are to get the same basic amount of money that we would have gotten had it come directly to us. It provides the Assistant Secretary with some flexibility to meet emergencies, or if there is a bright idea in vaccine development, it can be moved there, or something that can happen in epidemiology. But basically, all of PHS would get money the same way and as rapidly as we would as if it were appropriated directly to the Agency.

Mr. NATCHER. Doctor, how much will CDC receive for AIDS activities in 1987 and how does this compare with the original 1986 appropriation?

Dr. MASON. We will get $45.409 million. At least that is in the administration's proposal. And that compares with the 1986 appropriation of $64.925 million.

Mr. NATCHER. Why the reduction, Doctor?

Dr. MASON. Well, some of the money was for one-time activities. Part of the money that came to CDC was intended to go through that—let's say that there was a breakthrough in drug development, and through the testing that will be done by NIH, it was found that this drug is effective and safe.

Then there was one-time money that would be available that would make it possible to give that drug to people during the period between when it was shown to be safe and effective and when it was licensed and could be sold by the manufacturer.

AIDS PROBLEM SEVERITY

Mr. NATCHER. Dr. Mason, this may be the most serious problem that you have now as far as CDC is concerned, and I am referring to AIDS. Generally speaking, are we doing all right, Doctor? This is a serious matter, and would you say it is the most serious problem that you have had since you have been with CDC?

Dr. Mason. Absolutely. No question about that.

Mr. Natcher. Well, how do you feel generally about it, Doctor?

Dr. Mason. I feel that those things that can be done or should be done, are being done by CDC and the other agencies within the Public Health Service.

Mr. Natcher. Doctor, if you had your way and you were in full control, would we be doing anything that we are not doing on this side, on the appropriations side?

Dr. Mason. I think the foci of prevention includes risk reduction at the local and state level, the vaccine research, chemotherapy research, and protection of the blood supply. I think we have all of the components of the program as part of the PHS plan. I can't think of anything else that you would want to include in that plan.

Mr. Natcher. Dr. Mason, we need all the help we can get on this committee in matters like AIDS and other matters that are of serious concern to our people. That is the reason I am asking you these questions.

So I am just wondering now if we are doing everything that we should be doing at this time. You feel real good about it up to this point?

Dr. Mason. My assessment is that we are doing everything that should be done. I think one has to raise the question that it is more than just what should the Federal Government do. This is a national problem, and I believe that we are going to have to have the maximum input, not only at the Federal level, but the state level and the local level. We can only successfully combat this disease if all of these components are providing funds, and providing manpower to see that this epidemic is brought under control.

Mr. Natcher. I agree with you, Dr. Mason. I think you are exactly right.

AIDS PLANS FOR 1987

How would you spend the $45,400,000 for AIDS in 1987? How will this money be spent?

Dr. Mason. I am going to ask Dr. Hopkins to outline——

Mr. Natcher. Dr. Hopkins, go right ahead.

Dr. Hopkins. Thank you, sir.

We are going to concentrate in several areas, one being that of surveillance and epidemiology: that is, to maintain our finger on the pulse of the country in terms of the trends with respect to this disease as well as continuing investigations of the way the disease is transmitted; such things for example as studies of the families of persons who have contracted this disease because of IV drug abuse or because of a transfusion associated with hemophilia, to just be sure and study the different possible potential modes of transmission of this virus.

In the laboratory, we have undertaken and intend to continue studies related to better ways to diagnose this infection, to development of animal models so that we can study it more carefully, and also to continue work pertaining to development of a vaccine and treatment.

A large proportion of the money will also go to state and local health departments to help them to implement health education and risk reduction projects. In this area we have some of the funds being earmarked for highly-impacted local areas as well as for trying to help the country develop in every state a core capacity to assess the extent of AIDS in communities which haven't been heavily impacted so far, as well as for developing plans for putting in place information and education projects in those other communities.

Mr. **Natcher**. Thank you, Doctor.

AIDS PLANS FOR 1986

You will spend about $20 million in 1986 for AIDS risk reduction and health education activities. Can you describe now to us in a little more detail how these funds will be used? Go ahead, Dr. Hopkins.

Dr. **Hopkins**. We are using several different approaches in the health education risk reduction area. As I mentioned, we have some of that money earmarked for the heavily impacted areas to augment their ability to undertake health education and risk reduction projects.

We have also directed money up to 45 different state health departments to help them develop their capacity, those that are not heavily impacted so far. Our goal here is to have every state health department in the country have the capacity to assess the AIDS problem and begin information and education projects against it.

We have also earmarked a part of this money for a smaller number of education projects in which we are going to have concentrated control efforts, starting out with assessments of the extent of HTLV-III infection in the community, assessment of the knowledge of people about it and certain practices associated with AIDS transmission, and then putting in place intensive education and information projects and measuring the effect of those projects.

So we are trying to, as rapidly as we can, working with the state and local health departments, help the entire country get up to speed on this problem with the information and education but also having set aside some of the money for intensive demonstration projects so that two, three or four years from now, we will have a much better idea about what types of information and education projects work most effectively.

Mr. **Natcher**. Thank you, Dr. Hopkins.

Mr. Conte, I yield to you.

Mr. **Conte**. Dr. Mason, I want to join the Chairman in welcoming you before the Subcommittee. You have had a pretty action-packed tenure in the Department, especially last year when you were both the Director of CDC and Acting Assistant Secretary for Health.

I imagine you feel a little bit relieved and a lot happier now that you have dropped the extra role.

Dr. **Mason**. That is correct, although Dr. Hopkins was carrying a heavy role during that same period and did a wonderful job.

Mr. **Conte**. Well, congratulations to you and Dr. Hopkins, too.

AIDS BLOOD TEST

Doctor, your agency recently completed a study of the new AIDS blood test. What were the results of that study and how accurate is the AIDS blood testing procedure?

Dr. **Mason**. I am going to ask Dr. Hopkins to respond to that.

Dr. **Hopkins**. We might have Dr. Bennett give some more of the details, but with the American Red Cross, we did an intensive study involving, I believe, 75,000 blood donations, and through that means we were able to demonstrate that, contrary to some predictions, the blood test was very sensitive and very specific used in that blood bank setting.

I would add that we now think the serologic test would detect at least 95 percent of any units of positive blood which would be donated.

AIDS ALTERNATE TEST SITES FUNDING

Mr. **Conte**. That's pretty good. In fiscal year 1985, this Committee gave you authority to spend $10.4 million for the development of alternative sites to conduct the AIDS blood test. Did you get requests from states and localities for all that money, and how much of it was obligated?

Dr. **Hopkins**. Yes, we did. We spent the $10.4 million. I think, $9.7 million, almost $9.8 million of that was for state awards, and the balance for training state employees. We don't have complete reports on this yet because some of the areas still have more time to give us reports. Our partial information indicates that by the end of calendar year 1985, approximately 1,000 sites were set up around the country. That included 400 sites in New York City, in which they counted each individual physician as an individual site. But through those sites, partial information is that some 79,000 tests that had been done by the end of 1985.

Dr. **Mason**. Mr. Conte, the proportion of positives in some of these alternative sites was so high that it leads us to believe that this was a very valuable effort in protecting the blood supply by diverting people to the alternative sites, rather than having them go into the blood banks where they hoped to find out if they were positive or not.

Mr. **Conte**. Doctor, the Department just issued a recommendation that all Americans at high risk of contracting AIDS should undergo regular testing for the virus. The alternative sites are one place where these high risk individuals should go for those tests, are they not?

Dr. **Hopkins**. Yes. The objective of that was to try to help detect persons who were asymptomatic, that is, who don't have AIDS but are serologic positive and, from what we know now, are presumably able to infect other persons. The recommendation was that this serologic test should be offered routinely in places where high risk persons are seen, such as sexually-transmitted disease clinics, places where prostitutes are examined, places where IV drug abusers are brought in for treatment, and places of that type.

Mr. **Conte**. Doctor, if you have just come out with this recommendation that will most likely increase the use of blood tests, why are you proposing to rescind $10 million that we gave you for the alternative sites for fiscal year 1986? Did we give you too much money?

Dr. HOPKINS. When that approximately $10 million was originally requested and appropriated, we informed the states at that time that the purpose of this was to help them get up to speed quickly. The advance notice that they had had that this test was going to be licensed was relatively short. There was great concern, as you recall, that with all of the uncertainty, that some people in high risk groups might go to blood banks to be tested; but the intention from the very beginning was that this one time money would help the states to get up to speed on establishing alternate sites.

Some of the other information and education monies which we are making available will be used to help support some of that kind of testing.

Mr. CONTE. So you really don't need the money, and that is why you are asking for a rescission?

Dr. HOPKINS. We feel that the intention was to have one-time start-up costs for the states to help them get in place the kinds of systems that are needed.

Mr. CONTE. Well, let me put it this way, because I don't want to embarrass you. If we don't rescind the money, and I don't think we will, are you going to make good use of that $10 million?

Dr. HOPKINS. We think we would.

Mr. CONTE. All right. That is good. Put in the record what you are going to do with it.

[Information to be furnished follows:]

DISPOSITION OF AIDS RESCISSION FUNDS

If funds for alternate sites for HTLV-III antibody testing were not rescinded, we would announce the availability of funds in the Federal Register. Eligible applicants would be the official public health agencies of State governments, including the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, the Trust Territory of the Pacific Islands, the Northern Mariana Islands, and American Samoa; and local health agencies serving high morbidity areas. Awards will be based on an objective review of all applications, using criteria such as the extent of community support for alternate site testing, the success of past efforts in establishing and operating alternate sites, the estimated number of persons who will seek testing, and the procedures for assuring maximum confidentiality of all records relating to counseling and clinical laboratory test results.

AIDS SAFER PRACTICES PROMOTION

Mr. CONTE. We put $21 million in the bill last year for an education campaign to stop the spread of AIDS by promoting safer practices among homosexuals and other high risk groups. As far as I know, nothing has been produced. Why has it taken so long to produce this kind of material, and when do you expect to have all that money obligated?

Dr. HOPKINS. Mr. Conte, in fact the earlier part of this week we made an announcement of the availability of that grant money and the terms under which we would entertain requests for use of it on January 27th. We received several applications. I think the deadline for application was March 3rd. We reviewed those applications on Monday and Tuesday of this week. We expect to make those awards by the 15th of next month.

The reason for the delay was that in working with the so-called innovative risk grants, we began to get indications that some of the material which might be proposed for use in some of these grants might be of a type that would offend many people, and we wanted to ensure that the money was used effectively while showing that we are good stewards of the taxpayers' money. We felt we had to have in place guidelines for the kinds of material which we felt should and should not be supported; that is the development of them with Federal funds. It took some time for us to develop those guidelines.

Mr. **Conte**. Well, I was reading an article here where it says "Federal health officials cannot decide whether to put duty ahead of embarrassment in handling sexually explicit materials for an educational campaign to reduce the spread of Acquired Immune Deficiency Syndrome—" and it goes on and on. Have you resolved that yet?

Dr. **Hopkins**. Yes.

Dr. **Mason**. I think we have always had duty in front of us. One of the concerns that many people have raised is whether these monies could be used to promote another lifestyle, instead of directly counteracting AIDS. That was not the purpose of the money and I do not think most of the recipients would have used it for that purpose.

But we have now set up a procedure where there will be a community based committee, so to speak, which will oversee the materials that will be used, to make sure that they are not offensive to community standards, or do not seem to eroticize or promote an alternative lifestyle, for which the money was not appropriated.

It has been a little delicate working through that, but I think the end result is going to be acceptable to everyone. We do not know of anyone who is critical of the final outcome. But you are right, it has taken a little longer than if this had not come up.

AIDS CASUAL TRANSMISSION

Mr. **Conte**. I can understand the problem.

Doctor, the Director of Research Resources was here the other day, and said that in some of their monkey colonies it appears that the monkey AIDS virus had been spread between monkeys in different cages. On the other hand, your justifications talks about a study you did on family members of AIDS patients that points in the other direction.

What were the findings of that study and what do they show about the casual transmission of the AIDS virus?

Dr. **Hopkins**. Mr. Conte, we have over 300 instances now of 300 individuals who have been family contacts of persons who have had AIDS. They are living in the same house with persons who contracted AIDS because of IV drug abuse or because of hemophilia. And in none of those instances have we seen evidence of casual transmission of this virus.

One can point also to over 1700 people who have been followed very carefully, working in hospitals intensively with patients with this virus. And in those instances, as well, there is no evidence that this virus is transmitted in any of the other ways, or any ways other than those which we have pointed out.

The third area of evidence is when one considers the intensive scrutiny that this whole epidemic has brought, no one has been able to point to even one pair of people living in a household anywhere in this country where there has been transmission of the virus and the known modes of transmission are all able to be excluded.

In all of those instances, one can point to either congenital transmission, from a mother to an infant, or sexual transmission between parents in the household.

Mr. CONTE. You are familiar with those problems discussed by the Director of DRR?

SIMIAN AIDS

Dr. MASON. I think it is important to spell out the difference between simian AIDS and human AIDS. They are two different viruses. We know that this whole area of retroviruses is a complex issue.

As you know, there are viruses that affect sheep, horses, and others. And they fall into various classes. In our experience, as well as all the information I have on NIH studies, when you put human AIDS virus into chimps or primates, there is no transmission even between chimps in the same cage, much less in adjacent cages.

So I think what we are seeing with simian AIDS and human AIDS are not the same things. One would not expect them to be the same things because they are different viruses.

Mr. CONTE. I appreciate that explanation. It is a little confusing. Joe?

Mr. EARLY. Thank you.

EFFECT OF ALTERNATE TEST SITE RESCISSION

Dr. Hopkins, on the $9,934,000 rescission for site testing for AIDS, you said that these funds were for startup costs and to accelerate the development of alternative blood testing sites. I have a letter from someone in Maryland—in Wisconsin. It says "Through the CDC a number of agencies in the Wisconsin area are providing alternate sites for AIDS testing. If the President's request is honored, the Wisconsin agencies would lose $160,000 and the current program would be abolished. The effect to such a budget change could lead to some very serious consequences to patients in Wisconsin, consequences that could potentially spread to any blood source in the nation."

First of all, is this letter accurate?

Dr. MASON. I think that we need to restate that when these monies were initially made available, it was clearly spelled out that it was one-time, 90-day money to enable them to get geared up to begin this responsibility that we see as basically a local one.

Mr. EARLY. Well, wait a minute. You said it was startup costs. You are saying that it stipulated for 90 days?

Dr. MASON. That is right. It was made very clear. We hoped that by giving them notice that this is 90-day money, that the city and county health officials would go to their mayor or county health official, and that state health offices would go to their legislators and get the money so that this kind of activity can be carried on.

I think it is really unfortunate where a community has not geared up. This is a major epidemic, a major problem. I think we have to accept that there will be some response at the local level. I think that is unconscionable, when we have told them that it was one time money, that they would then come back this way.

Mr. Early. Doctor, we tell a lot of states that it is one time money. We are also counting out revenue sharing. My city uses revenue sharing for police and fire services. They are going to have to replace that.

You say it is a joint effort. The state of Massachusetts is joining in the fight for AIDS. We came up with $1.3 million. New York City and California have, too. Do you expect that the really poor states are going to be able to come up with the money to fight this problem, which you say is a local problem? It is more of a national problem, a national threat, than I have ever seen.

Dr. Mason. It involves all of this, that is right.

Mr. Early. And it is interesting. I know you have to defend this budget, Dr. Mason, but you are going to defend it, too, if we have a continance or a growth of the outbreak of AIDS. You told Mr. Natcher we are doing what can be done, should be done, and would be done.

Is this budget going to slow you down in what you can be doing and what you should be doing and what you would be doing, doctor?

Dr. Mason. Well, you can always use more money and you can allow the local level to back out because federal money is coming and so they do not need to provide that money. But I think, with the national debt being what it is, we have got to look to more responsiveness at the local level.

Mr. Early. All right. But we do not want to get into a lot of detail about whether we should increase Star Wars by $3 billion. This is your specialty.

Earlier, you told me you had to transfer experts from other places to put them onto AIDS. Evidently, we do not have a flow of trainees that were able to supplant the ones we have to replace, doctor. So I just think we are not getting there fast enough.

I listened attentively to both you and Dr. Hopkins, and the other directors that have come in. The other directors have at least acknowledged that we are not stopping it, in the budget you are not stopping it.

But let me ask Dr. Hopkins, do you think you are slowing anything down?

Dr. Hopkins. I do not think that across the board we are. I was going to add that while we have proposed a rescission of that $9.9 million for the alternate sites in 1985, in fiscal year '85, we provided $16.6 million to the states. This year, without the alternate test site money, we are awarding on the order of $25.9 million to the states.

We are not calling any of that alternate test site money, but it is money which is going out to the states for combatting AIDS at the state and local level. And in this budget we still have, again without the alternate test site money, a proposal for approximately

$21.8 million that would be going out to the states to help combat the AIDS problem.

So while the money under that rubric is proposed for rescission, even through this one CDC federal channel, the total amount of money being devoted to AIDS at the community level, risk reduction and health education, has been increasing.

Mr. Early. It has in Massachusetts, but Doctor, that first chart showed one, the number of cases reported in one year has doubled; and two, the number of deaths has doubled. And neither one of you said, at any time, that these reductions are going to slow you down at all.

And I want to make sure that we are on the record that you are suggesting that the reductions are not going to slow you down?

Dr. Mason. Well, we just have to say to you that they were provided on a one-time basis and——

Mr. Early. Well, I am not talking about just the site testing. Where I have trouble, Dr. Mason, and you are one of the experts in the country, is suggesting that the states and local governments should pick it up. It sounds good. It sounds wonderful. If they can. And if they do not, do we not have a national responsibility—do you think it is adequate that we told them to pick it up, but they could not?

I mean, what is our responsibility then?

Dr. Mason. Many of the communities will be able to pick those up.

Mr. Early. But twice as many will not be able to pick them up, Doctor. I mean, you know, we have got outbreaks in Massachusetts of tuberculosis, the other disease that Dr. Lane and I spoke of earlier, hepatitis and you know, as far as—I think Massachusetts will pick them up because they see public health as a number one item.

HEMOPHILIA-RELATED ACTIVITIES

But let us get on to hemophilia. Can you give me some direction about CDC support for the Hemophilia Foundation AIDS Risk Reduction Education Program? How much has been allocated in '86 to this activity?

Dr. Mason. To the National Hemophilia Foundation and the hemophilia-related activities?

Mr. Early. Yes.

Dr. Mason. Mike, do you want to report on that, Dr. Lane?

Dr. Lane. We have set aside something in the order of $1.8 million for the hemophiliacs and we had discussions, correspondence, and phone calls with the National Hemophilia Foundation. We do not have, yet, a formal proposal and request in from them and it may be that, instead of giving them money directly, they will ask us to give money to our sister agency, HRSA, and have them supplement the existing grants to hemophilia foundations for specific AIDS counseling and risk reduction activities.

Mr. Early. How much in '87, Dr. Lane?

Dr. Lane. It would be an analogous amount. We have made that specific determination. In the order of $1.8 million.

AIDS FUNDING MECHANISM

Mr. **Early**. In response to one of the questions, on the route of the funding, you do not have any reservations on making one more indirect stop before the money gets to you? I mean, at least my own intention with the monies appropriated for AIDS last year—and this is just my own—we put in an additional $70 million. I never suspected that they were going to go into each institute and take the intramural and extramural funds and take funds for the clinical trials they had going on, and that money was going to have to go through that. But that does not bother you?

Dr. **Mason**. We think we can live with that without any trouble. We are glad that Dr. Dowdle, who is coordinating AIDS at the PHS level, is a CDC employee and we feel that we will get a fair shake in this overall distribution.

Mr. **Early**. But as the Director, you do not have a philosophical problem of that going through another route before it stops——

Dr. **Mason**. Well, philosophically, I tend to agree with you. But if someone makes a decision to put it initially in the Office of the Assistant Secretary and then give us what we need to get the job done, that does not bother me. I have trust and confidence that the system will work expeditiously.

Mr. **Early**. Well, who do you think did that? Who made that decision, Doctor? My own intention was that the additional $70 million—the additional, not what was funded in AIDS already—I did not think he was going to control all the Institute's money for AIDS.

Thank you, Mr. Chairman.

Mr. **Natcher**. Mr. Dwyer.

DIOXIN EFFECTS ON WORKERS

Mr. **Dwyer**. Doctor, last year NIOSH was appealing a ruling by OMB, rejecting your plan to study the effects of dioxin on workers at plants in New Jersey and Missouri. What is the status of that appeal?

Dr. **Mason**. I would like to ask Dr. Millar to give you a report.

Dr. **Millar**. We have, Mr. Dwyer, of course pursued that because we think the studies are important. The present status is that the protocol was rejected by OMB on October 17th of 1985. We appealed that rejection on December 12th, 1985. OMB then gave us approval to proceed with an initial phase of the study. And that approval came in January of 1986.

In that initial phase, it was approved as to involve basically a pilot project involving 80 exposed workers and 80 controls. And after an initial phase is completed, we will report back to OMB on our findings and resubmit the full project, hoping at that time to be able to convince them of the value of moving forward.

The target date for completing that initial phase will be about March 1987.

Mr. **Dwyer**. Thank you, Doctor.

TOXIC WASTE EXPOSURE

Doctor, I understand that last year CDC solicited grant applications for various studies on the effect of exposure of toxic wastes on pregnancy and child birth. What was the response of the solicitation?

Dr. **Mason**. This was the CDC study on its employees or was this Superfund?

Mr. **Dwyer**. Superfund.

Dr. **Mason**. I would like to call upon, if I might, Mr. Chairman, Dr. Houk, who is the Director of the Center for Environmental Health and has been directing our agency for toxic waste and disease registry. Dr. Houk.

Dr. **Houk**. This is part of a planned effort to look at all of the adverse reproductive outcomes in association with toxic dumps. We are using Superfund monies and plan to initiate cooperative agreements in about eleven states within the next two or three years.

The response of the states has been relatively overwhelming, Mr. Dwyer. As you know, many of the states are very interested in doing this.

Mr. **Dwyer**. So you have a lot of respondents who actually want to participate. How far along is it?

Dr. **Houk**. If Superfund had been reauthorized now, we would be in the process of adding five more states this year. That has been put on hold pending the reauthorization and funding of the Superfund legislation.

Mr. **Dwyer**. What states responded originally?

Dr. **Houk**. I can't give you all of them. I can provide that for the record.

Mr. **Dwyer**. Doctor, was New Jersey one of them?

Dr. **Houk**. I believe so. I'm not certain.

[The information follows:]

Application for Studies on the Effect of Exposure of Toxic Wastes

The following are the States that responded through their State Health Departments to our RFP for Superfund Cooperative Agreements: New York, Wisconsin, Connecticut, Indiana, New Jersey, Washington, Florida, Missouri, Illinois, Michigan, Colorado, Idaho, Maryland, Texas (Dallas County), and, Vermont.

The following applications were submitted by Universities/Institutes: Harvard College, University of California (Davis), University of Iowa, University of Arkansas, University of Alabama (Birmingham), and University of West Virginia Medical School.

MEASLES

Mr. **Dwyer**. Thank you. Just one more question. You mentioned measles earlier in your opening statement. You are keeping it under 3,000 cases annually.

Dr. **Mason**. That's correct.

Mr. **Dwyer**. Yet the graph indicates that the cases have actually gone up for the last two years. Am I correct?

Dr. **Mason**. That's correct. We have probably reached our low in 1983 and we have been fighting in the trenches to hold it down to that level ever since. I could ask Dr. Lane to give you——

PERTUSSIS

Mr. **Dwyer**. The same thing is true of whooping cough or pertussis; isn't it? Has that started to creep up, too?

Dr. **Mason**. Pertussis is a little higher this year than it has been, but I think for very different reasons.

VACCINE SUPPLY

Mr. **Dwyer**. I see you have a six month supply of vaccine on hand.

Dr. **Mason**. Our vaccine stockpile is intended to be a six month supply. We have about two-thirds or 17 weeks of the six month supply currently on hand.

Mr. **Dwyer**. Is it a serious problem?

Dr. **Mason**. We feel that a six month supply is really very important because there can be an interruption of vaccine supplied for a number of reasons. That six month stockpile then provides some flexibility while those problems are overcome.

Mr. **Dwyer**. I see in the justifications you are postponing any more additions to the vaccine stockpile until the liability issue is resolved. How long will that take? That particular problem has been around a long time.

Dr. **Mason**. Yes; it has. The six month stockpile was designed primarily to handle interruptions in supply because of a strike at a manufacturing plant, or if there was inadvertently a lot that did not meet FDA requirements. It would give them time to start up a new batch. It was never designed to handle the complexities of this liability issue that is now facing us.

Mr. **Dwyer**. Is that a decision that was made by your Department not to proceed with the stockpiling until the liability question was resolved? Was that made by OMB?

Dr. **Mason**. We recommended that we continue with the stockpile. At other levels, they felt with additional vaccine manufacturers entering the market, changes perhaps in the pertussis component of the DTP vaccine, and now with the licensure of hemophilus influenza vaccine, that it was a good time to stand back and reassess the situation before we proceed probably in 1988.

Mr. **Dwyer**. If I understood what you just said, there was a financial judgment made rather than a professional medical judgment made. That is what I gather from your words.

Dr. **Mason**. That's right.

Mr. **Dwyer**. Thank you, Mr. Chairman.

NUTRITION SURVEILLANCE

Mr. **Natcher**. Dr. Mason, last year Congressman Mickey Leland of Texas called to our attention the possible need for closer monitoring of severe malnutrition in this country. What kind of nutrition surveillance system does CDC currently have?

Dr. **Mason**. I would be happy to describe those, Mr. Chairman. We call it our pediatric nutrition surveillance system. I have to make it very clear that in this system, we are looking at mothers, infants, and children that enroll in the Women-Infants-Children program, the distribution of agricultural products. We are monitoring the maternal and child health clinics that are Federally funded. We are evaluating children in Medicaid clinics.

Our pediatric nutrition surveillance system is really directed at that group and our results, therefore, may not represent the nation as a whole. We have focused on that group.

I would like to call upon Mr. Dennis Tolsma, who is Head of the Center for Health Promotion and Education, who is directly responsible for that activity, to give you a report on what we have found.

Mr. Natcher. Go right ahead.

Mr. Tolsma. Thank you, Mr. Chairman.

As Dr. Mason pointed out, these data are data that reflect the status of low income children participating in these various public clinic settings and pregnant women seen in these same settings.

When one looks at the problem of measuring the nutritional status of people, basically the data that we have look at indicators of poor nutrition. These are such things, for example, as being short for age, called stunting, in nutritional terms, or short stature. We look at anemia. We look at underweight and overweight for the particular age and size of the children.

Looking at young children in these clinics over a number of years we have found that the situation with regard to these poor nutrition indicators does not seem to show increases. In fact, there is probably a modest improvement in these indicators of poor nutrition. We do have to say that these are children who have, as a group, excesses when compared to what we would expect to find in a normal group of children. There are some increased problems in that group in comparison to what we would call a reference population, in other words, what the norm would be for that particular group.

Mr. Natcher. How much do you budget for this, both staff and dollars?

Mr. Tolsma. In 1987, it is approximately $1.4 million for the nutrition status monitoring. I don't have the number of staff directly available. I can supply that for you. We basically are assisting the states, sir, to obtain this information, so the state staff are the principal resource here to accumulate this kind of information out of the records of the children they are seeing, from that, we are able to build a composite description of the status of the children, both in the national data set that we accumulate but also for the individual states and individual clinics.

They use that information to try to ascertain where they have the most serious problems. It is a way of directing their nutrition services towards the highest risk problems.

[The information follows:]

Nutrition Budget and Staffing

The CDC assistance provided to States supports a limited nutrition surveillance system since not every State has the capacity to participate and, even in participating States, coverage may be limited. In FY 1986 the Pediatric Nutrition Surveillance System has 34 State participants who submit approximately 1.9 million records a year to CDC. Seventeen States participate in the Pregnancy Nutrition Surveillance System and submit records on approximately 93,000 pregnancies per year. The CDC budget has $1.44 million and 16 FTE for nutrition surveillance to provide technical assistance and promote uniform procedures to enable those States to place groups at high-risk for nutrition problems under surveillance.

Mr. NATCHER. In your opinion, do we have a severe malnutrition problem in certain parts of our country?

Mr. TOLSMA. As I said, in the population we look at, we can only describe the status of those children who are actually receiving services. We do not have the ability to speak to the possibility that there are children who are not receiving services who may or may not have nutritional problems.

We know that there are some excesses in indicators of poor nutrition for these children. We know that problem does not seem to be increasing. We know that there are from time to time young, very small infants seen in hospital settings and these children often appear to be malnourished. The problem is what is, the underlying reason for that? It is a very complicated question. We are in fact trying to develop a way to sort out what are the reasons for what appear to be very small or very undernourished children.

Mr. NATCHER. Would it be feasible to expand the nutrition surveillance system to include reporting of severe malnutrition cases?

Mr. TOLSMA. Sir, I think the problem we have faced in doing that, in considering your question is that it is very difficult to come up with a definition that all researchers and clinicians accept, to get them to use the same definition, and therefore, to report the same thing.

We have looked at this in pediatric admissions to hospitals. We are trying to develop a method that would allow us to come to agreement on what is a case of malnutrition so that when it was reported, we could be sure that what was being reported was truly the same health problem in each area. We would like to be able to have that kind of data. I think there is a methodological problem that has to be solved first. We are working on it.

Dr. MASON. I was just going to say the problem is that a child is admitted to the hospital malnourished and if you just reported that, you wouldn't know whether the hunger problem was due to lack of food, lack of information, or to an underlying disease problem. We need to progress to the point where we can say not only that it is a malnourished child, but can link the information to the cause of that malnourishment. Is it an organic disease? Is it lack of parental knowledge? Is it because the family just didn't have the wherewithal to feed it? That would have to be tied in with that reporting system to make it useful.

GONORRHEA

Mr. NATCHER. We see that the incidence of gonorrhea increased in 1985 for the first time in five years. How do you account for this?

Dr. MASON. Again, it is probably not a simple answer to give you. We have to admit that some of it may be due to the shifting of resources from gonorrhea to AIDS. Both of them are sexually transmitted diseases. There has been some shift in some communities which may be playing a role. There are other factors.

As one looks at the pattern across the nation, in some cities, it went down and in others, it went up. We have multiple factors.

Mr. NATCHER. Mr. Early, go right ahead.

VACCINE STOCKPILE

Mr. **Early**. Dr. Mason, the vaccine supply or stockpile, the ideal stockpile by the experts is 26 weeks. You say you are down to what right now?

Dr. **Mason**. We are not down. We have just never gotten up to 26. We have gotten up to an average of about 17 weeks.

Mr. **Early**. What happened? There is no money in the 1987 request before this Committee for the stockpile?

Dr. **Mason**. That's correct.

Mr. **Early**. When would the stockpile diminish to ten weeks?

Dr. **Mason**. We hope we will not need to pull from that stockpile. If someone were unable to distribute DTP or oral polio vaccine or whatever, then we would draw upon the stockpile and in that case it would diminish.

Mr. **Early**. I hope we are not basing it on that product liability which is a big, big problem. I don't know how we would be responsible to suggest that we haven't addressed that in Congress at all in over 200 years and we are now going to address it and we are going to let the stockpile go down.

BUDGET REDUCTION-EFFECT ON AIDS

Doctor, on your justification for 1986, originally you had appropriated $471,861,000. The budget request before us is for $379,846 less the AIDS money. You showed me a chart that showed AIDS, which you identified to the Chairman as the biggest threat you have had since you have been the Director.

I want to know, with this drastic reduction of almost $90 million or $54 million, if you include the AIDS, that you are not concerned that you are slowing down too much. Your AIDS was going like that [indicating] on the chart. I think research is how quick we get there. You say you are not stopping it. Are you slowing it down?

Dr. **Mason**. Mr. Early, thus far, as we have identified needs for AIDS money, we have been able to get Congress to address that as we have gone up from CDC to PHS to HHS. Since it is a rapidly moving disease, we have to use that budget process. I think our scientists, our epidemiologists, and our field staff have been provided with the necessary resources. As they have identified new needs, and we have gone through that process and then those resources have been forthcoming.

Mr. **Early**. They suggested to us earlier the vaccine was three years away. What are we going to say? Three more years and justify a budget that will not give you the tools to do so?

Dr. **Mason**. The vaccine may indeed be three years away or even longer. We have to be working at the community level to do something about that transmission, the behavior of people that relate to transmission.

Mr. **Early**. Doctor, as far as transferring from here to there, you have to do it because it is your priority, are you satisfied with how fast we are training people to pursue CDC type of specialties?

Dr. **Mason**. With the pressures upon us from Gramm-Rudman-Hollings and other things, this is not a time where, because of deficits, we can expand. We are simply trying to maintain as best we can the high priority programs that we are responsible to carry out.

AIDS INFECTION RATES IN PROSTITUTE[illegible]

Mr. Early. It is our opinion that our priorities, whether Star Wars or in the other type of increases in the budget or whether it is in your area, which to me is a bigger threat than any of the others as far as the threat of a bubonic plague type of thing—I have seen a study that shows that of the unregulated prostitutes in Germany, 90 percent of them have AIDS.

Would any of your people deny that? Can you tell me what percentage of prostitutes in New York City have AIDS?

Dr. Mason. We have done studies here in the United States and cities where we have a lot of AIDS cases. It will vary from a survey where you will get none to as high as 40 percent in the United States. I can't vouch for the overall 90 percent in Germany. I would be very willing to admit that if you took a small group and tested them, that you might come out with 90 percent. That is a little high for overall rates.

Mr. Early. Maybe Dr. Hopkins wants to address it. The military did a study that shows that the two prostitutes in Germany, regulated and unregulated. I understand the unregulated is just unregulated because of drug users and it is 90 percent. I get unbelievable suggestions of what the AIDS carriers, the prostitutes in New York City, numbers are.

Dr. Hopkins. I would just in part repeat what Dr. Mason has said. The numbers vary, to the extent that we have them. I am familiar with one study in Miami that showed a rate of about 20 percent AIDS carriers in a small prostitute population. There are some areas in East Africa where the rates of positivity among prostitutes are very high. I don't remember having seen numbers quite as high as 90 percent.

Mr. Early. Just unregulated.

Dr. Hopkins. More than 70 percent. One of the messages we are trying to get out is that a prostitute does not have to be an IV drug abuser to be at high risk for this infection. By virtue of prostitution and frequent sexual contacts, there is risk of them getting AIDS as well.

Mr. Early. From those numbers, it looks like the prostitute and a drug user is maybe five or six times probable to be a carrier.

Dr. Hopkins. She certainly is at greater risk than a prostitute who is not an IV drug abuser.

Mr. Natcher. Dr. Mason, we want to thank you and your associates for appearing before our Committee at this time, on behalf of your budget request for fiscal year 1987. This has been a good hearing. We appreciate it.

Dr. Mason. Thank you very much, Chairman Natcher.

Mr. Natcher. The Committee will now recess until 2:00 this afternoon.

[The following questions were submitted for the record:]

VACCINE COSTS

Mr. Natcher. By what percentage have vaccine costs risen over the past two or three years?

Dr. Mason. Vaccine costs for childhood immunization programs have risen as follows since 1984:

	84 Prices/Dose		85 Prices/Dose		86 Prices/Dose	
Vaccine	Private Sector	Public Sector	Private Sector	Public Sector	Private Sector	Public Sector
DTP	$ 1.19	$0.98*	$ 2.80	$2.21	$ 4.20	$2.21**
TOPV	$ 4.27	$0.73	$ 5.11	$0.80	$ 8.07	$1.56
MMR	$12.80	$5.40	$13.53	$6.85	$15.15	$8.47
Td	$ 0.54	$0.10*	$ 0.57	$0.08	$ 0.57	$0.08***
DT	$ 0.55	$0.15*	$ 0.64	$0.11	$ 0.64	$0.14***

	84-86 % Change	
Vaccine	Private Sector	Public Sector
DTP	253%	126%
TOPV	89%	114%
MMR	25%	57%
Td	6%	-20%
DT	16%	-7%

*Representative State contract price. All other public sector prices are CDC contracts.

**Current contract expires 4/23/86.

***Current contract expires 6/30/86.

Mr. Natcher. How will you meet these rising vaccine costs with a level budget?

Dr. Mason. The $47,666,000 requested for grant funds in 1987 is $2,343,000 more than the 1986 revised level. Of this, $32,882,000 will be needed to purchase the same proportion of measles, mumps, rubella, and polio vaccine as was purchased in 1986. The remaining $14,784,000 will be used by the grantees to offset the increasing cost of DTP vaccine and/or fund other State and local immunization program operation activities.

NUMBER OF CHILDREN VACCINATED

Mr. Natcher. Wouldn't fewer children be vaccinated in 1987 under your proposed budget?

Dr. Mason. The 1987 budget proposal is sufficient to purchase the same number of polio and MMR vaccines (12.7 million doses) and enable the same number of children to be vaccinated against these diseases as in 1986. If the States choose to purchase DTP vaccine with all of the $14.8 million in the 1987 request not needed for MMR and polio vaccines, approximately 3 million doses of DTP vaccine could be purchased in 1987. This would represent about 0.5 million DTP doses less than we expect to be purchased with grant funds in 1986, and would mean that States would have to support the purchases of about 0.5 million more doses of DTP vaccine in 1987 than they did in 1986, and provide funds for State operations. It should be noted, though, that Federal immunization grant funds have only been used to purchase DTP vaccines since 1985.

VACCINE SHORTAGES

Mr. Natcher. Are there any vaccine shortages at this time?

Dr. Mason. The current supply of vaccines is adequate. However, Lederle has indicated that it is having problems in obtaining adequate insurance and will have to consider halting distribution of DTP vaccine. The liability issue remains the major threat to continuing supplies of vaccines.

VACCINE LIABILITY PROBLEMS

Mr. Natcher. Are you making any progress in resolving the liability problems in vaccine manufacture?

Dr. Mason. In March 1985, the Cabinet Council on Human Resources formed a Working Group on Vaccine Supply and Liability. Membership in the Group included representatives from the White House, the Office of Management and Budget, the Department of Justice, the Department of the Treasury, the Council of Economic Advisers, and the Department of Health and Human Services.

The Working Group found that punitive and non-economic damages are the large, and generally unpredictable, part of many vaccine-related awards. There is little justification for punitive damages in cases of vaccine-related injury since vaccines are strictly regulated under Federal law. The Group also concluded that a cap on non-economic damages (pain and suffering, mental anguish, emotional distress, etc.) was reasonable if set at a generous level. Non-economic damages are based on subjective judgment, and have a significant effect on vaccine cost. By contrast, although economic damages vary somewhat from State to State and case by case, they generally fall within a broad range for particular types of injuries.

After examining several options, the Working Group recommended that the Administration seek the enactment of legislation to ban punitive damages in vaccine-related injury cases and to place a generous but reasonable cap on all non-economic damages. This proposal has been forwarded to the Congress. Enactment of this proposal would greatly reduce the threat of vaccine manufacturers leaving the market and could encourage other manufacturers to enter the market. This would not only increase the availability of vaccine, but also help contain its increasing cost.

This problem is very complex; developing a reasonable solution will be very difficult and will require close cooperation between all parties. Rapid and rational action is imperative, to assure that we have a continuing supply of these life-saving vaccines.

INFANT MORTALITY

Mr. Natcher. You have one program increase in 1987, namely $1,750,000 for an infant mortality initiative. Tell us why you are requesting this money and also how you will spend it.

Dr. Mason. The Administration recognized the importance of this program and provided the funding. Recent examination of the 1990 Objectives has indicated that many of the pregnancy and infant health objectives are unlikely to be achieved by 1990. The realization that we will fail to reach the 1990 Objectives comes at the same time that several major reviews of the problem have suggested that large proportions of neonatal/postneonatal mortality are preventable with existing interventions. At the Federal level, there has been increasing concern over the inability to lower the prevalence of low birth weight and the very large discrepancies in infant survival between the disadvantaged and advantaged segments of our society.

The components of the Infant Mortality Initiative build upon recent PHS initiatives and activities. These components provide support for improved data collection/surveillance and State-based epidemiologic investigations into causes of and solutions to low birth weight.

Recent data from CDC's National Infant Mortality Surveillance Project reveal that low birth weight among infants is a major factor associated with neonatal and infant mortality, especially for black infants who experience twice the risk of low birth weight as compared with white infants. Moreover, low birth weight is associated with maternal health behaviors during pregnancy, such as use of cigarettes, alcohol misuse, and poor nutritional practices. Cessation of health risk behaviors can have a positive effect on birth outcomes. The surveillance of behavioral risk factors in pregnancy will provide a comprehensive mechanism to help States:

- better assess the extent of health behavior risks,
- identify those populations at highest risk,
- target their intervention efforts,
- provide data for evaluating progress towards 1990 objectives related to low birth weight

This mechanism builds on existing systems which cannot adequately serve this purpose without substantial enhancement.

Through this initiative we will provide direct analytic assistance to three States to help them assess their program effectiveness, thereby refining a model which over the next three to five years, can build the epidemiologic capability of State maternal and child health divisions. This assistance will consist primarily of epidemiologists, directly assigned to State health departments, coupled with backup consultation and analytic support at CDC.

CHLAMYDIA CONTROL

Mr. Natcher. Has the chlamydia control program been sidetracked because of Gramm-Rudman?

Dr. Mason. Funds allocated for the sexually transmitted disease program to date have not specifically addressed a nationwide chlamydia prevention and control program. However, because of the serious public health consequences for both mothers and infants infected with chlamydia, CDC has over the past 2 years restructured priorities and placed increasing emphasis upon the development of effective prevention and control programs for chlamydia. This increased emphasis will continue in FY 1986 within the limitations of Gramm-Rudman-Hollings cuts. The original FY 1986 appropriation included an increase of approximately $1.3 million. CDC intended to use the entire amount on the expansion of a nationwide chlamydia prevention and control effort. The reductions required by Gramm-Rudman-Hollings amounted to $2.4 million for the Sexually Transmitted Disease Program, which will compromise--but not totally negate--its ability to increase activity in the area of chlamydia control. CDC will continue to emphasize the more cost effective strategies recommended in the recently published "Chlamydia trachomatis Infections: Policy Guidelines for Prevention and Control." The two major components of these recommendations are presumptive diagnoses based on syndrome, and dual therapy which will cure both gonorrhea and chlamydia infections.

Mr. Natcher. Do you plan to increase your chlamydia control efforts in 1987?

Dr. Mason. In FY 1987, an estimated 10 percent of grant funds, or $4.6 million, will be directed toward chlamydia prevention and control activities. Direct operation funds, which have included several research and demonstration projects, will stabilize. With these funds, CDC will continue to emphasize the most cost effective recommendations in the chlamydia guidelines; encourage States to implement reporting laws and legislation, which will provide support for prevention activities to assure adequate individual patient management; and continue to improve the surveillance system for collecting and monitoring reported cases of chlamydia or associated syndromes.

NIOSH GOALS

Mr. Natcher. What will be the major goals of the National Institute for Occupational Safety and Health (NIOSH) in 1987?

Dr. Mason. NIOSH will be pursuing the following goals in FY 1986 and FY 1987:

1. Continuing work to direct research towards preventing the NIOSH Ten Leading Work-Related Diseases and Injuries. This includes sponsoring the second national symposium where NIOSH staff and other members of the occupational safety and health community can meet to review draft strategies prepared by NIOSH for preventing these diseases and injuries, and establishing NIOSH research objectives in accordance with the prevention strategies.

2. Continuing efforts to increase State health department participation in occupational safety and health. This includes continuing to fund cooperative agreements

providing assistance to the States for capacity building and surveillance; to perform joint health hazard evaluations; and to collaborate with States in investigations of fatal work accidents.

3. Continuing to provide leadership in the area of national occupational safety and health surveillance. Highlights include developing a national surveillance network including State health departments, private health care providers, and industrial medical departments; improving standardization of illness and injury reporting by developing operational definitions for occupational disorders; and convening a national symposium to review surveillance of occupational health problems.

4. Continuing to emphasize health promotion in the workplace through demonstration projects, collaboration with State health officials, and creation of an improved health risk appraisal instrument incorporating general occupational safety and health risk factors.

5. Explore future directions for occupational health and safety, including holding a joint symposium with Finland on the changing nature of the workforce.

NIOSH EMPLOYMENT

Mr. Natcher. How many employees does NIOSH currently have?

Dr. Mason. NIOSH has 815 employees.

Mr. Natcher. Will that number stay about the same through 1987?

Dr. Mason. We believe we will have approximately the same number of employees. The budget includes the same number of FTEs for both years.

NIOSH CRITERIA DOCUMENTS

Mr. Natcher. How many criteria documents were issued in 1985?

Dr. Mason. We completed two criteria documents in Fiscal Year 1985: Recommendations for Control of Occupational Safety and Health Hazards ... Foundries, and Occupational Health Technical Guidelines for the Ceramics Industry.

OCCUPATIONAL HEALTH SURVEILLANCE SYSTEM

Mr. Natcher. Have you made any progress in improving the surveillance system for occupational injuries and illnesses?

Dr. Mason. One of our major initiatives is to improve national occupational disease surveillance capabilities. We are pursuing the goal of establishing the uniformity in disease definitions needed for developing reliable surveillance sources. We have made the following progress over the past year:

- o Established a new position - Assistant Director for Surveillance and Epidemiology - to coordinate all NIOSH occupational injury, illness, and hazard surveillance.
- o Continued the program of surveillance cooperative agreements with States last year (SCANS and capacity building increased from 14 to 15 States).
- o The Bureau of Labor Statistics made the SHE(o) a part of their proposed guidelines for the OSHA 200 log.
- o Proposed questions to be added to NHANES III on specific occupationally-related health conditions; e.g., lung diseases, musculoskeletal, neurotoxic disorders, hearing loss, and dermatologic conditions.
- o NIOSH, NCHS, and the States have made cost sharing arrangements that will provide incentives for States to systematically record industry and occupation on death certificates. This will decrease the fragmentation and increase the reliability of mortality-based data systems.

NIOSH SCIENTISTS

Mr. Natcher. Does NIOSH have any difficulty in recruiting and keeping top-flight scientists?

Dr. Mason. This has not been a problem. We offer a unique opportunity for researchers in occupational safety and health. NIOSH is the only Federal research agency authorized by law to enter into workplaces and access company records to evaluate work conditions. In addition, our research program canvases the broad field of occupational safety and health, allowing researchers to investigate problems in a truly multidisciplinary approach. We employ scientists in numerous specialties such as engineering, epidemiology, industrial hygiene, ergonomics, toxicology, analytical chemistry, occupational medicine, dermatology, and neurology.

EDUCATIONAL RESOURCE CENTERS

Mr. Natcher. For the record, provide a list of the Educational Resource Centers showing the amount of Federal funds that each receives.

Dr. Mason. For FY 1985, Educational Resource Centers received the following amounts:

NIOSH Educational Resource Centers	Funding
ALABAMA EDUCATIONAL RESOURCE CENTER University of Alabama, Birmingham Auburn University	$466,845

BEST COPY AVAILABLE

CALIFORNIA EDUCATIONAL RESOURCE CENTER - NORTHERN University of California, Berkeley University of California, San Francisco University of California, Davis	$541,218
CALIFORNIA EDUCATIONAL RESOURCE CENTER - SOUTHERN University of Southern California University of California, Irvine California State University, Fullerton UCLA	$549,121
CINCINNATI EDUCATIONAL RESOURCE CENTER University of Cincinnati	$527,810
HARVARD EDUCATIONAL RESOURCE CENTER Harvard University Boston University	$495,026
ILLINOIS EDUCATIONAL RESOURCE CENTER University of Illinois, Chicago	$516,896
JOHNS HOPKINS EDUCATIONAL RESOURCE CENTER Johns Hopkins University	$554,881
MICHIGAN EDUCATIONAL RESOURCE CENTER University of Michigan, Ann Arbor	$556,171
MINNESOTA EDUCATIONAL RESOURCE CENTER University of Minnesota, St Paul	$465,907
NEW YORK/NEW JERSEY EDUCATIONAL RESOURCE CENTER Mt. Sinai School of Medicine Hunter College New York University Rutgers University	$510,315
NORTH CAROLINA EDUCATIONAL RESOURCE CENTER University of North Carolina, Chapel Hill Duke University North Carolina State	$671,484
TEXAS EDUCATIONAL RESOURCE CENTER University of Texas, Houston Texas A & M	$367,200
UTAH EDUCATIONAL RESOURCE CENTER University of Utah	$596,991
WASHINGTON EDUCATIONAL RESOURCE CENTER University of Washington	$548,040

INJURY CONTROL

Mr. Natcher. What is the current status of the Congressional initiative to establish an injury control center at CDC?

Dr. Mason. Congress has appropriated $10 million dollars to the Department of Transportation which is to be provided to CDC to initiate a three year pilot project to implement the recommendations of the National Academy of Sciences report, Injury in America. CDC has provided 20 FTEs as directed by the House. DOT and CDC staff have met several times to coordinate the transfer of funds and to plan for the implementation of the recommendations of this report. CDC is doing the necessary internal planning and processes necessary to establish the expanded injury program. We expect the money to be transferred and a program established to implement this law within the next two months.

Mr. Natcher. How much money do you expect to receive from the Department of Transportation?

Dr. Mason. CDC expects to receive $10 million dollars, less the amount sequestered for Gramm-Rudman, which is a total of $9,785,000.

Mr. Natcher. Do you plan to make 20 FTE's available for this?

Dr. Mason. Yes. CDC has augmented the 32 existing injury control FTE's with an additional 20 FTE's.

TRAUMA RESEARCH

Mr. Natcher. Do you agree generally with the findings of the National Academy of Science's Committee on Trauma Research?

Dr. Mason. Yes. CDC fully agrees with the findings of the National Academy of Science's Committee on Trauma Research.

VIROLOGY LABORATORY

Mr. Natcher. When will your new virology laboratory be completed?

Dr. Mason. The laboratory is scheduled to be completed in December, 1987.

Mr. Natcher. What will be the total cost, including equipment?

Dr. Mason. The building cost is $19,513,000. Equipment built into the building cost $1,946,000. Additional movable laboratory equipment costing $5,487,000 will be needed. This would make the total cost $26,946,000.

Mr. Natcher. How much of that has not yet been appropriated?

Dr. Mason. Of the $5,487,000 requested for scientific equipment in the 1986 budget request, Congress appropriated $1,987,000, of which $85,000 was sequestered, and balance of $1,902,000 is proposed as a rescission.

AGENT ORANGE STUDY

Mr. Natcher. What is the status of the so-called Agent Orange study that you are doing for the Veteran's Administration?

Dr. Mason. The status of three components of CDC's Epidemiological Studies of the health of Vietnam veterans is as follows:

- Vietnam Experience Component - This component is divided into three related studies:

  1. Health Interview - The health interviews are virtually complete (14,611 interviews have been conducted) with an overall response rate of about 85%.

  2. Examinations - A total of 2,922 veterans have been examined to date and it is projected that about 4,100 veterans will have been examined by September 1986.

  3. Mortality Study - A final draft of the mortality assessment report is now undergoing review.

- Selected Cancers Component - Progress on this component has been satisfactory with interviews completed on 302 cases and 219 controls. Scheduled completion date is September 1989.

- Agent Orange Exposure Component - Initiation of the Agent Orange exposure component of CDC's Epidemiological Studies of the Health of Vietnam Veterans has been delayed pending the Office of Technology Assessments review and approval of a revised study protocol. Activities related to protocol development are ongoing by the U.S. Army and Joint Services Environmental Support Group, the Agent Orange Working Group Science Panel, and CDC.

Mr. Natcher. How much has been expended to date for this?

Dr. Mason. Through the end of the first quarter FY 1986, $56,898,653 have been obligated for all components of CDC's Epidemiologic Studies of the Health of Vietnam Veterans.

CENTRALIZED AIDS FUNDING

Mr. Roybal. Congress in its 1986 reconciliation report language urged the Public Health Service to create a coordinating mechanism (probably at the Asst. Secretary for Health level) to manage and direct the various PHS agencies' AIDS programs. OMB subsequently interpreted the report to mandate a centralization of 1987 AIDS appropriations in the Asst. Secretary's office, under the direction of an AIDS coordinator. This has been formally proposed in the 1987 budget submission. But is centralizing AIDS-related funding the answer to a need for coordination?

Dr. Mason. The centralizing of AIDS-related funding is not directly in response to the report language. The Assistant Secretary has established a coordinating mechanism in his office. Dr. Dowdle of CDC is now acting in that capacity.

The proposal to centralize the AIDS funds is to provide the Assistant Secretary some flexibility to respond to emergencies, or to new directions in AIDS research and/or prevention activities.

Mr. Roybal. Secretary Bowen has stated in hearings that he doesn't favor the creation of a new bureaucracy to coordinate AIDS activities. Given his view, does it make sense to centralize and disburse AIDS-related appropriations from one source in PHS?

Dr. Mason. We are not opposed to the idea and do not anticipate problems in implementing the plan. We anticipate receiving the funds budgeted for CDC as rapidly as if they had been appropriated directly to us.

Mr. Roybal. Would centralized funding impinge upon the ability of individual agencies to expedite their AIDS activities? (NIH specifically has expressed concern that monies might be held up in endless "reviews," or that political considerations could stymie certain programs.)

Dr. Mason. We do not anticipate any problems with the plan.

Mr. Roybal. Would centralized funding deprive Congress not only of its right to specify generally what needs to be done by which agency, but also to monitor appropriations as they are in fact spent?

Dr. Mason. Congress should be able to get the same information to monitor funds under this plan just as they would if the funds were appropriated to each agency.

SEQUESTRATION OF AIDS FUNDING

Mr. Roybal. To what extent is the current sequestration of appropriated AIDS funds -- ostensibly to satisfy Gramm-Rudman cuts as well as proposed rescissions -- holding up urgently needed programs that both Congress and the Administration have already approved?

Dr. Mason. The Gramm-Rudman cuts are only having minor effects on the AIDS programs. The proposed rescissions would only eliminate continuation of what was intended to be one-time start-up support for AIDS alternate test sites, and the expansion of the current AIDS hotline to 24 hours, seven days a week.

AIDS CAPACITY BUILDING GRANTS

Mr. Roybal. Are states and localities really capable currently of conducting sophisticated AIDS public education and prevention programs? At roughly $115,000 per grant, are CDC's 1986 capacity-building grants to facilitate this expertise really sufficient to address the need, particularly in areas where incidence of disease is low and transmission could conceivably be slowed or stopped?

Dr. Mason. The purpose of capacity-building grants is to help the States appraise their AIDS health education needs and develop the capacity to deliver health education/risk reduction programs. The ability of each State to accomplish this initial assessment planning, and then program implementation, will depend more on quality management and organization than on large levels of funding. While the funding is a necessary stimulus, the key is to draw together the impressive array of voluntary and otherwise supported resources concerned with AIDS available in each community. These funds can also help States secure the talented, dedicated personnel needed to bring all available resources to bear on the AIDS problem. Therefore, CDC believes that the amount of funds awarded is less important at this point than how effectively the States put them to use. This is true whether the incidence of disease is high or low.

In coming months, CDC will be providing close technical support to the States to assist their management staffs in developing a core capacity for Statewide health education/risk reduction programs. Beginning in April, CDC also will be offering training to provide State managers with the skills and knowledge necessary to facilitate the organized collaboration of community level resources, and to plan, implement, and evaluate an effective AIDS health education program.

AIDS EDUCATION AND PREVENTION

Mr. Roybal. Could AIDS education and prevention be handled more effectively by regional centers rather than centrally at CDC? Would it make more sense to transfer technology and expertise to say, six regional centers (such as Centers for Interdisciplinary Research on Immune Disorders, which are already directed to conduct education), which could tailor substance and programs for their particular regions?

Dr. Mason. There are three reasons why it is felt that AIDS education and prevention are better handled centrally at CDC rather than through regional centers (such as Centers for Interdisciplinary Research on Immune Disorders). First, the AIDS education and prevention program authorized by Congress focuses on operations and service delivery rather than research. CDC has the capability of managing both types of programs, but is particularly experienced in the former. Transferring the technology and expertise for this to regional centers would require duplication of this expertise in each of the regional sites. Second, the AIDS prevention and education programs are to be implemented through grants to State and local health departments with whom CDC has an effective and long standing relationship. Third--and perhaps most important--the field of AIDS is changing technologically and strategically at such a rapid pace that centralized management is imperative to facilitate rapid adjustments down to the service delivery level. The ability to effect such change in a timely and uniform manner is not judged to be improved by using a regional layer.

Mr. Roybal. Why is the majority of AIDS education funding being made available only through state and local public health authorities? Because so many of those authorities are not up-to-speed on AIDS, are they able to spend funds wisely and effectively? Wouldn't it make sense to make much more funding available to any institution, including those in the private sector, capable of demonstrating the ability to carry out effective programs?

Dr. Mason. AIDS is a public health problem which legally falls within the purview of the official health agencies in each State and locality. Under statute and regulation, such agencies have well defined responsibilities for the control of communicable disease within their respective jurisdictions. Therefore, while many public and private community groups and organizations have an interest and some experience in dealing with various facets of the AIDS problem, CDC believes that the coordination and augmentation of their efforts as part of CDC funded programs should be the responsibility of the health department.

CDC also believes that the official health agencies are in the very best position to balance all of the different interests and viewpoints of various organizations, help to coordinate and focus their energies, and augment their efforts for an effective overall community-based programs of AIDS health education and risk reduction. CDC further believes that private sector institutions which can contribute to the overall AIDS control effort in a particular community will make their interest known, but that decisions regarding local roles and resource allocations are best made by the official health agency which can most objectively make those judgements.

AIDS RESCISSION

Mr. Roybal. The proposal to rescind $11.8 million in AIDS projects from CDC seems incongruent with the Administration's statements that AIDS is our "highest priority" in public health. What is the justification for rescinding these funds?

Dr. Mason. I think one has to raise the question that it is more than just what the Federal Government can do. This is a national problem, and I believe that it will require the maximum input from the Federal, State, and local levels if we are to successfully combat this disease.

Mr. Roybal. What evidence do you have that States will be able to continue the alternative testing sites without the $9 million which you proposed for rescission? If the funds are not rescinded will you proceed quickly to disburse these funds for the purpose intended?

Dr. Mason. Funds in FY 1985 for alternate testing sites were made available to States and certain large cities having many cases of AIDS on the understanding that these were "one-time, start-up" resources. The number of alternate sites in operation expanded to about 520 in September, when all cooperative agreement recipients still had grant resources remaining, and went up to nearly 1,000 sites by the end of December, when half or more of the recipients had already spent their awarded funds. According to available estimates, the latest figure remains in tact, suggesting that States are now supporting their alternate testing sites without the $9 million proposed for rescission.

If the funds are not rescinded, CDC will proceed to announce their availability, solicit applications for funding, and make awards at the earliest possible opportunity.

VIROLOGY LABORATORY EQUIPMENT

Mr. Roybal. Will the delay in purchasing the non-fixed scientific equipment for the virology laboratory (i.e. proposed rescission of $1.9 million) have any impact on CDC's work with the HTLV-III (AIDS) virus?

Dr. Mason. The AIDS laboratories are planned to move into the new virology laboratory. Since AIDS is the number one health problem, we would strive to prevent any impact on CDC's work with the HTLV-III virus.

Mr. Roybal. Did the proposal to rescind the $9 million originate with CDC or OMB?

Dr. Mason. The rescission proposal reflects the agreement between the Department and OMB on ways to more precisely control the level of overall expenditures. As part of the Department, CDC did not initially recommend a rescission of these funds.

TB RATES

Mr. Roybal. Recent information suggests that the TB rates are not dropping as fast as expected and that the phenomenon may be related to the prevalence of AIDS. Given that increase from the expected rate of TB and the problem of its prevalence among the homeless and minorities, how can you justify the elimination of this program? What assurances can you provide that the "alternate" sources of funding can take on the additional responsibility of this $5 million dollar program when the 1986 revised request for those 2 programs has been reduced by $2.3 million below their 1985 level?

Dr. Mason. It is correct that tuberculosis rates are not dropping as fast as expected. We are very concerned about the leveling off of the downward trend in the incidence of this disease in the United States and we are looking closely at the problem. The provisional total of 21,801 tuberculosis cases reported for 1985 (case rate of 9.13 per 100,000) is a decrease of only 2.0 percent from the final tuberculosis case total for 1984. During the previous three years (1982, 1983, and 1984), tuberculosis morbidity declined an average of 6.7 percent.

Although the reasons for the relatively small decline in 1985 cases are not fully known, we have evidence that human T-lymphotrophic virus type III/lymphadenopathy-associated virus (HTLV-III/LAV) infection of persons infected with the tubercle bacillus has caused a tuberculosis increase in some areas.

CDC epidemiologists and tuberculosis program personnel are working closely with health departments in Florida and New York City on studies to better define and understand the tuberculosis/AIDS/HTLV-III problem and to design the most effective and efficient control strategies. We do not know the precise incidence of tuberculosis among the homeless in the United States because most State and local health departments do not collect or report to CDC information on homeless tuberculosis patients. However, the homeless, as well as many of our nation's minority citizens, are from lower socioeconomic groups where tuberculosis case rates are generally higher. In Fiscal Year 1984, 7,650 cases were reported in Blacks, 2,466 in Asians, 2,750 in Hispanics, and 375 in American Indians. Although case rates were significantly higher for Blacks, Hispanics, and American Indians than for Whites, the case rate for each subpopulation is declining at approximately the same rate.

State and local governments have traditionally assumed the responsibility for most of the costs of prevention and control of tuberculosis in the community. We believe many States will allocate Preventive Health Block Grant or other funds for tuberculosis control activities that are now funded by the $5 million Tuberculosis Cooperative Agreements. Most State and local health departments, particularly those with significant tuberculosis problems, recognize the need to keep the disease in check. Experience with the Tuberculosis Cooperative Agreements since 1982 has demonstrated the effectiveness of intensified prevention and control activities in many high incidence areas. Some areas have reported substantial cost savings because noncompliant patients who previously needed to be hospitalized for treatment of tuberculosis can now be treated successfully on an outpatient basis. Based on the experiences in using the Tuberculosis Cooperative Agreement funds, the States are now in an excellent position to evaluate funded activities and determine where they rank among the other priorities of the States. We are convinced that many States will want to continue applying the outreach technologies developed through the grant where they have proven to be cost effective versus the alternatives of continued community spread or costly long-term hospitalization of noncompliant patients.

In general, it is believed that the block grant approach is the most effective way for the Federal Government to assist States to address public health and other problems. This approach is consistent with the Administration's commitment to balance the budget. Block grants permit States to establish their own priorities and to direct funds to those problems which they perceive to be the most urgent. Furthermore, the 1987 budget request for the Refugee Preventive Health program (in the Office of Refugee Resettlement) is $10.3 million, an increase of $2.3 million over the 1986 level. Funds from this program are available to State and local health agencies for TB control, therapy, and follow-up for those refugees identified as being TB infected and eligible for preventive treatment.

Mr. Roybal. Where are the diabetes control projects located? What portion of the funds in each State have been targeted toward the groups which have a high prevalence of diabetes, e.g., blacks, Mexican-Americans, and Native Americans?

Dr. Mason. The diabetes control projects are located in:

California
Colorado
Georgia
Illinois
Kentucky
Louisiana
Maine
Michigan
Minnesota
Mississippi
Missouri
Nebraska
New Jersey
New York
Ohio
Pennsylvania
Rhode Island
South Carolina
Utah
Washington

The following States have received awards for diabetic eye disease programs only:

Florida
Kansas
Maryland
Massachusetts
West Virginia

Although States have been encouraged to target high-risk populations, and indeed the above mentioned groups are often among them, in most States it is difficult to identify specific funds which have had an impact on any specific group. One exception is the project dealing with the Ute tribe of Native Americans in Utah in which approximately 50 per cent of Utah's cooperative agreement funds were allocated for this project over the past 5 years.

Mr. Roybal. Given the findings reported by the DHHS Task Force on Minority Health on increased prevalence of diabetes among minorities and other data which suggests minorities are less likely to see a physician for care of this disease, shouldn't we be doing more, not less, to control the disproportionate occurence of this disease in minority groups?

Dr. Mason. CDC's Diabetes Control Program recognizes the burden of diabetes on minority populations. Diabetes Control Program States have been encouraged to target these high risk populations for inclusion in their project activities. This includes populations which may be at high risk because they are minority and/or medically underserved. The Diabetes Control Program is also working with the Health Resources and Services Administration (HRSA) to insure that state-of-the-art diabetes care is available within federally supported primary care centers.

VIOLENCE STUDIES

Mr. Roybal. What level of support has been allocated for CDC studies on violence? Please provide brief descriptions of the epidemiological or intervention studies which have been supported.

Dr. Mason. CDC has allocated $344,000 for such studies on intentional injury (violence). A description of epidemiological or intervention studies are as follows:

- CDC is engaged in several projects relating to the epidemiology of intentional violence. Among these is a study of over 5,000 homicides in Los Angeles, completed this year.
- CDC is preparing a Minority Homicide Surveillance Report on selected high-risk racial and ethnic minorities.
- CDC has initiated investigations into the phenomenon of adolescent suicide clusters and the feasibility of developing suicide attempt surveillance systems. Operational criteria for the classification of suicide by medical examiners and coroners are being field tested.
- CDC has been involved in working groups from the Secretary's Task Force on Youth Suicide.
- CDC is reviewing case records of domestic homicides and nonfatal assaults in Atlanta to fill a void in existing knowledge about the patterns of contact by victims and perpetrators of violent intimate assault with criminal justice, medical, and social service agencies.

Mr. Roybal. Is CDC planning any new effort in this area as a result of the findings of the DHHS Task Force on Minority Health?

Dr. Mason. CDC is committed to epidemiologic research in the area of minority health and intentional injuries. It participated as an active member on the Secretary's Task Force on Black and Minority Health to assist in the preparation of a report on suicide, homicide, and injuries.

We published a Morbidity and Mortality Weekly Report article (February 7, 1986) monitoring the Nation's progress toward achieving the 1990 Objective of reducing the homicide rate among black males aged 15-24 years. While this rate fell 33.5% between 1970 and 1982, it still remains more than five times as high as the rate for white males in this age group.

We have documented patterns of homicide among Hispanics in five southwestern states and the city of of Los Angeles. These studies showed that Hispanics have a risk of homicide that falls midway between that for blacks and white, non-Hispanics.

The collaborative homicide study in Los Angeles and the Minority Homicide Surveillance Report, discussed above, are expected to serve as stimuli for continued epidemiologic research on black and minority homicide, as well as community efforts to prevent homicide.

WORK WITH THE HEMOPHILIA FOUNDATION

Mr. Roybal. What steps has CDC taken to work with the national Hemophilia Foundation on AIDS in response to House, Senate and Conference report language?

Dr. Mason. CDC has been in communication with the National Hemophilia Foundation regarding their proposed comprehensive plan to provide AIDS risk reduction education for hemophiliacs and the significant others in their lives. While a number of details remain to be clarified, we support the concept and intend to support the Foundation in implementing this activity. In addition, CDC will work through official health agencies receiving AIDS-related cooperative agreement support to include establishing collaborative relationships with each local Comprehensive Hemophilia Treatment Center.

REPORT ON BLACK AND MINORITY HEALTH

Mr. Stokes. Former Secretary Margaret Heckler's task force report on black and minority health documented significant health disparities between whites and blacks in the areas of infant mortality, cancer, cardiovascular disease, diabetes, chemical dependency, and homicide, suicide and accidents. As you know, the report was released in October 1985. What role did the Centers for Disease Control play in the development of the report?

Dr. Mason. The task force involved persons and agencies from throughout the Department, including CDC. Dr. Donald Hopkins, who is my Deputy Director and who was serving as CDC's Acting Director when this report was being prepared, was a member of this task force. Much of the surveillance data on intentional and unintentional trauma, diabetes, and on risk factor behaviors was provided by CDC. Such data was used to document the disparities that you have noted, and supports the recommendations made by the task force.

Mr. Stokes. What will CDC do differently this year in order to respond to the recommendations in the report?

Dr. Mason. Since surveillance and the gathering of epidemiologic information are central to CDC's activities, its programmatic efforts in prevention are consistently directed toward populations at highest risk for the leading causes of death, disease, and disability. Consequently, black and other minority populations constitute a substantial proportion of those who receive services through programs directly or indirectly influenced by CDC.

In addition to CDC's traditional activities, many of our health promotion efforts have been, and will continue to be, targeted toward minority populations. For instance, our study of an exercise program among Zuni Indians, whose rate of non-insulin dependent diabetes is almost twice that of other adults in this country, has shown that community based exercise programs in this minority population can be effectively implemented, and can contribute to significant weight loss and a reduction in hypoglycemic agent dependency.

We expect our smoking and pregnancy pilot project, that is specifically directed toward low income women, to make a substantial contribution toward improving infant morbidity and mortality outcomes. Our Community Intervention Guides, some of which will be available in 1987, address important risk factors among minority populations. Of course, our school health initiatives provide young people with preventive learning opportunities of proven effectiveness, irrespective of racial or ethnic status.

INFANT MORTALITY INITIATIVE

Mr. Stokes. With regard to the high infant mortality rates among blacks, I note that your budget request includes $1.75 million to fund "two new components of the PHS Infant Mortality Initiative". These components are the pregnancy nutrition surveillance system and the behavioral risk factor surveillance system. Please describe the purpose of these initiatives and what you hope to accomplish through them.

Dr. Mason. Essentially the CDC components of this initiative are targeted toward the same goal--to improve State capacity to identify women at high risk of poor pregnancy outcome, and to increase State analytic capacity to use information to increase the effectiveness and efficiency of existing program efforts.

This will be accomplished through the development and enhancement of two data collection mechanisms--pregnancy nutrition surveillance and behavioral risk factor surveillance. These mechanisms have the potential to address the need for critically important information on behavioral risk factors in pregnancy. State-based surveillance would be enhanced by increasing the monitoring of behavioral risk factors of major importance to infant health--particularly smoking and alcohol use. These enhancements will significantly increase State capacity to monitor health-related behaviors associated with poor pregnancy outcome, and to use the information to direct intervention efforts more precisely and efficiently to those areas and populations in greatest need. The program improvements should lead to a reduction of premature death and preventable morbidity in our most vulnerable population--infants of low income parents.

DIABETES AMONG MINORITY AMERICANS

Mr. Stokes. The task force report on black/white health status also highlighted the disproportionate problem of diabetes among minority Americans. Yet, your budget includes a rescission of $4.785 million to discontinue the State diabetes projects and no funding is requested for these projects in FY 1987. It seems to me that this proposal will set back efforts to prevent and control diabetes in minority populations. Please comment.

Dr. Mason. Over the past 5-8 years, 20 States have been federally funded to carry out diabetes demonstration projects. The goal of these programs has been to reduce complications of diabetes by developing patient and provider education programs and improving the health care delivery system. A secondary goal of the program has been to achieve self-sufficiency. Many of these projects have been shown to be cost-effective and have developed comprehensive State plans for diabetes control and/or have ongoing community based projects. Because of the need to constrain Federal spending, we believe it is now appropriate for these demonstration projects to be continued by the States or other third-party payors who have also benefitted financially from their success.

In 1984, four to five States made in-kind contributions of approximately $3.5 million while 15 other States have contributed a total of $1 million. In several States, third-party payers now cover the cost of certain services such as patient education. This number is expected to increase. In addition, other non-project States, such as Texas, Maryland, Iowa, and North Dakota, have either started their own diabetes control programs or secured third-party reimbursement for patient education without Federal financial support.

CDC will continue to provide technical assistance, develop consensus, and actively disseminate information on effective control and evaluation strategies. We will also continue to encourage States to establish linkages with organizations providing funds for service delivery in order to capitalize on existing resources, and will encourage use of block grant funding for diabetes control efforts.

STATES WITH DIABETES CONTROL PROJECTS

Mr. Stokes. How many States now have diabetes control projects?

Dr. Mason. There are currently comprehensive diabetes control cooperative agreements with 20 States. Five of these 20 and 5 additional States have recently received diabetic eye disease intervention cooperative agreements.

Mr. Stokes. Please list these States for the record.

Dr. Mason. The 20 current State diabetes control programs are listed below:

California
Colorado
Georgia
Illinois
Kentucky
Louisiana
Maine
Michigan
Minnesota
Mississippi
Missouri
Nebraska
New Jersey
New York
Ohio
Pennsylvania

Rhode Island
South Carolina
Utah
Washington

The following 5 States have diabetes eye disease programs only:

Florida
Kansas
Maryland
Massachusetts
West Virginia

CHILDHOOD IMMUNIZATION BUDGET

Mr. Stokes. How much is included in your FY 1987 budget for childhood immunization activities? How does this compare with FY 1986 and FY 1985?

Dr. Mason. The proposed 1987 budget for the immunization grant program is $47,666,000. This compares to $45,323,000 for the revised 1986 appropriation and $42,400,000 appropriated in 1985.

IMPROVING IMMUNIZATION LEVELS

Mr. Stokes. Last year, Dr. Mason, you indicated that improving immunization levels among preschool children, especially in inner cities and rural areas, was a top priority. What have you done to address this problem since the last time you were here?

Dr. Mason. We continue to have as a high priority improving immunization levels among preschool children. All recipients of grant funds have been urged to refine and more widely implement systems to recall children for vaccination when they fall behind schedule. Further, all recipients of grant funds have been asked to refine and more widely apply programs designed to educate new mothers while in the hospital about the importance of immunization and starting immunization on schedule. We have begun extensive evaluation of certain specific recall and hospital based education efforts to determine what materials and techniques provide the best yield in certain populations.

Eight in-depth reviews of State immunization programs were conducted in the past year. During these reviews, a team of individuals with extensive experience in immunization programming look carefully at all elements of a program including those elements that bear on elevating preschool immunization levels, and make recommendations to the program manager about how they can improve the program.

A review of the immune status of 2 year old children in many areas has been undertaken to see if we can identify reasons for incomplete immunization that can be corrected merely by changing clinical practices. We have developed a description of an automated information management system that will reduce the clerical burden on health care providers while, at the same time, make it easy for them to identify patients who are not following a recommended immunization schedule and recall them.

IMMUNIZATION OF ADULTS

Mr. Stokes. Reports have indicated that adults are under-immunized against such diseases as tetanus, diphtheria, measles, rubella, influenza and pneumonia. What activities do you have planned to increase the immunization of adults?

Dr. Mason. Planned activities to increase the number of fully immunized adults include a number of operational, technical/scientific, and educational projects. Examples of operational activities to accomplish these goals include developing and implementing a plan to obtain the support of prepaid health plans (health maintenance organizations) for adult immunizations, and developing guidelines for immunization of hospital and health department staff. Examples of technical or scientific activities are to identify denominator data on national adult target populations for each of the vaccines, and to locate or develop benefit/cost information on adult antigens. These data will enable the Public Health Service to better define the extent of the problem of under-immunized adults and to track progress toward the Public Health Service 1990 Objectives for the Nation. Examples of educational activities include writing, or coordinating, articles on adult immunization for publication in a variety of medical and lay magazines, newsletters, and journals; and developing prototype training and promotional materials, such as slides and pamphlets, to be disseminated to State and local health agencies for them to reproduce and distribute to the target populations and medical providers in their areas.

In addition, several activities are planned which cut across two or more of these classification lines and involve other national organizations and agencies. For example, CDC is identifying areas of potential research on operational and educational factors which influence the immunization status of adults. These factors are being explored in collaboration with other Federal agencies, such as the Veterans' Administration, with private medical associations, such as the American Academy of Family Physicians, and with special interest groups, such as the National Foundation for Infectious Diseases.

VACCINE STOCKPILE

Mr. Stokes. Dr. Mason, in previous years, you have discussed the CDC's goal of a six month vaccine stockpile. This year, your budget includes no request for vaccine stockpiling, even though I understand that we currently have only a 16 week stockpile. Is a six month stockpile still an appropriate goal? If not, why not?

Dr. Mason. The 6 month stockpile is still an appropriate goal. We should be able to provide an assured supply of vaccine in the event of short term (6 months or less) problems with vaccine manufacturing, lot testing, or strikes which have generated supply problems in the past. A 6-month time frame is based on an estimate by FDA that if production of a vaccine were totally interrupted, it would take at least 6 months to re-establish production.

VACCINES CURRENTLY STOCKPILED

Mr. Stokes. What vaccines are currently stockpiled?

Dr. Mason. Funds have been appropriated through FY 1986 which will provide an aggregate 17-week supply of the major childhood vaccines in the stockpile, compared to the goal of a 6-month (26 week) supply. Individually, by vaccine, the following table displays the supplies currently in the stockpile and those expected to be accumulated by the end of FY 1986:

	Current Supply	Est. Supply at end of FY 1986
OPV:	18 weeks (68.1%)	20 weeks (78.3%)
DTP:	10 weeks (37.7%)	15 weeks (56.7%)
MMR:	12 weeks (47.3%)	15 weeks (56.7%)
Td:	16 weeks (61.4%)	18 weeks (69.8%)
DT:	10 weeks (40.0%)	15 weeks (59.0%)
IPV:	8 weeks (30.6%)	17 weeks (63.3%)

* No DTP vaccine is currently in the stockpile (as of March 27). The ability of the contractor to meet its initial obligation to stockpile 37.7% of the 6-month target will depend upon production schedules and demands for vaccine. Current estimates are that the contractor will begin putting DTP vaccine in the stockpile in April 1986. Sufficient funds have been appropriated through 1986 to allow the eventual DTP stockpile to grow to 56.7% of the target amount.

NEW VACCINES

Mr. Stokes. The budget justification indicates that new vaccines for DTP and Haemophilus influenza B are being developed to replace existing vaccines. How soon are these new vaccines expected to be on the market?

Mr. Mason. New acellular pertussis vaccines are being developed and evaluated in several laboratories around the world at the present time. It appears reasonable to estimate from available information, assuming satisfactory results of clinical studies, that a new vaccine could be licensed in the U.S. by the end of the decade, possibly sooner. It is expected that a new Haemophilus influenzae type B polysaccharide vaccine given in combination with DTP vaccine at 2-4 months of age will be effective in infants. This vaccine is estimated to be available for use within 2 years.

CDC AIDS BUDGET

Mr. Stokes. What are the CDC allocations for AIDS under 1) the enacted FY 1986 budget, 2) the revised 1986 budget, and 3) the FY 1987 President's budget?

Dr. Mason. The CDC allocation for AIDS under the enacted FY 1986 appropriation is $64,925,000, the revised 1986 budget is $50,285,000, and the FY 1987 President's budget is $45,409,000.

AIDS EDUCATION AND RISK REDUCTION

Mr. Stokes. How much are you spending on AIDS education and risk reduction strategies?

Dr. Mason. In fiscal year 1986, $21,220,582 will be devoted to health education risk reduction activities. The current projection for fiscal year 1987 is that $22,157,481 will be devoted to this area.

Mr. Stokes. One of every four AIDS victims is black. What health education and risk reduction programs have been targeted at this group?

Dr. Mason. The fact that AIDS has most prominently affected white males has tended to obscure the reality that 25 percent of AIDS cases have occurred in blacks. The CDC cooperative agreements for AIDS Health Education/Risk Reduction are designed to assure that information is targeted to all segments of the community, and particularly to groups and individuals at high risk. Reaching blacks -- as well as hispanics, another minority group with a potentially high prevalence of AIDS -- is a concern already expressed by a number of States. CDC will be working closely with all States in the coming months to assure that the needs of the black and other affected communities are effectively addressed. One of the most visible programs to date has been in Philadelphia where an extensive campaign to increase awareness of AIDS in the black community is being conducted.

TB GRANT PROGRAM

Mr. Early. For several years you have been requesting the termination of the TB grant program. This year you are asking that we rescind the $4.785 million (post sequestration level) Congress provided for FY86, and you are not requesting funds for FY87. Have you received any indication from the states that they would be able to compensate for the loss of these funds by using their Preventive Health Services Block grant or Refugee Assistance funds?

Dr. Mason. We believe that many States will allocate Preventive Health Block Grant or other funds for tuberculosis control activities that are now funded by the Tuberculosis Cooperative Agreements. Most State and local health departments, particularly those with significant tuberculosis problems, recognize the need to keep the disease in check. Experience with the Tuberculosis Cooperative Agreements since 1982 has demonstrated the effectiveness of intensified prevention and control activities in many high incidence areas. Some areas have reported substantial cost savings because noncompliant patients who previously needed to be hospitalized for treatment of tuberculosis can now be treated successfully on an outpatient basis. Based on the experiences in using the Tuberculosis Cooperative Agreement funds, the States are now in an excellent position to evaluate funded activities and determine where they rank among the other priorities of the States. We are convinced that many States will want to continue applying the outreach technologies developed through this grant where they have proven to be cost effective versus the alternatives of continued community spread or costly long-term hospitalization of noncompliant patients.

In general, it is believed that the block grant approach is the most effective way for the Federal Government to assist States to address public health and other problems. This approach is consistent with the Administration's commitment to balance the budget. Block grants permit States to establish their own priorities and to direct funds to those problems which they perceive to be the most urgent.

Furthermore, the 1987 budget request for the Refugee Preventive Health program (in the Office of Refugee Resettlement) is $10.3 million, an increase of $2.3 million over the 1986. Funds from this program are available to State and local agencies for TB control, therapy, and follow-up for those refugees identified as being TB-infected and eligible for preventive treatment.

Mr. Early. Dr. Mason, the number of TB cases reported in Massachusetts has increased significantly. In 1985, 459 cases and 9 deaths were confirmed. This is an increase of 22% over the number of cases reported in 1984. According to State Public health officials TB is still a significant problem. And from what I understand there are several areas in the country that are also facing a serious TB problem. I believe this is an indication that the grant program should remain. If the program was terminated, as you propose, what assistance would be available from CDC to assist the States?

Dr. Mason. The CDC Division of Tuberculosis Control will continue to:

- o Provide prevention block grant funds that can be used by the States for TB control.
- o Provide technical assistance to State and local health departments to conduct programs designed to prevent and control tuberculosis.
- o Provide national leadership in the prevention and control of tuberculosis through the formulation and promotion of national policies, strategies, standards, and recommendations.
- o Collect and analyze tuberculosis morbidity and mortality data submitted by State and local health departments to identify problems specific to geographic areas, occupational groups, and institutional populations.

- Conduct operational research to develop, evaluate, and promulgate more rapid and effective diagnostic, treatment, and preventive methods.
- Evaluate national tuberculosis control efforts through collection and publication of "evaluation indices"; on-site program evaluations; and periodic surveys on such topics as tuberculosis screening practices and recurrent tuberculosis.
- Cooperate with other countries (especially in Southeast Asia and Mexico), the World Health Organization, the Pan American Health Organization, and the International Union Against Tuberculosis, in upgrading tuberculosis control programs in the United States and abroad.

In addition, in 1987 the Office of Refugee Resettlement is requesting $10.3 million which will be available to State and local agencies for TB control in refugees.

INCREASED TB CASES

Mr. Early. For the record, provide a list of the states which experienced an increase in the number of TB cases reported in FY85 as compared to FY84, and FY84 as compared to FY83.

Dr. Mason. The following tables indicate that 9 states experienced an increase in reported TB cases in Fiscal Year 1984 as compared with Fiscal Year 1983, and 15 states have reported provisional increases in Fiscal Year 1985 as compared with the final figures for Fiscal Year 1984.

States with an Increase in Reported TB Cases
1983 - 1984

State	1983	1984	Increase
South Carolina	443	544	101
Alabama	522	565	43
Maryland	409	428	19
Arizona	264	273	9
Ohio	519	528	9
Nebraska	25	30	5
North Dakota	9	14	5
Iowa	65	68	3
Kansas	76	77	1

BEST COPY AVAILABLE

Provisional Data
States with an Increase in Reported TB Cases
1984 - 1985

State	Final 1984	Provisional 1985	Number Increase
New York City	1630	1910	280
California	3306	3526	220
Massachusetts	376	444	68
Florida	1335	1383	48
New York Upstate	616	644	28
Washington	207	232	25
Arkansas	315	339	24
Georgia	784	808	24
Alaska	79	95	16
Montana	33	49	16
Louisiana	377	388	11
Maine	35	46	9
South Dakota	25	31	6
Kansas	77	81	4
Wyoming	5	7	2

STATE DIABETES PROJECTS

Mr. Early. If the funding for State diabetes projects was eliminated as proposed (a $4.785 million rescission is proposed), what technical assistance would CDC continue to provide the States who want to establish a diabetes control program?

Dr. Mason. CDC personnel with expertise in program implementation and management; evaluation; epidemiology; statistics; patient and professional education, and medical areas would be available to provide technical assistance to States. For example, public health advisors who are managers skilled in problem solving and program implementation could assist in program design. Epidemiologists would be able to provide input on evaluation design and data collection. Expertise on patient and professional education programs would be available upon request, and several knowledgeable physicians could be consulted on medical matters.

Mr. Early. How many States developed linkages with MCH or primary care centers? Would you give us an indication of what the States are doing to utilize already established delivery programs?

Dr. Mason. All 20 comprehensive State diabetes control programs and 3 of the 5 States with only diabetic eye disease cooperative agreements have developed linkages with MCH programs, and also with Federally funded primary care centers in each State. All of these States have been encouraged to develop strong ties to established programs such as those involved with hypertension control, stroke and heart attack prevention, and other chronic diseases.

Mr. Early. Have many States chosen to fund diabetes control activities from their Preventive Health Block grants? To what extent are these programs being funded?

Dr. Mason. The New York State diabetes control program had at one time obtained some funds from Preventive Health Block grants, but that has since been discontinued. The Pennsylvania diabetes control program continues to receive Preventive Health Block grant funds. Most State diabetes control programs have so far been unable to access these funds and, therefore, have chosen to seek alternative additional funds from other than Federal sources. In addition, States have used their own funds to expand their programs.

Mr. Early. How many States currently have diabetes control programs? And how many have received grant assistance from CDC?

Dr. Mason. Twenty States currently have diabetes control program cooperative agreements. Five of these also have a separate cooperative agreement for a diabetes eye disease intervention. Five additional States, not in the original 20, have only diabetes eye disease funds.

Mr. Early. How many new diabetes State project grants were funded in FY 1985? Which States were the recipients of these awards? What is the average size of the grants?

Dr. Mason. No States were newly funded for comprehensive diabetes control activities during FY 1985. However, ten cooperative agreement awards were made in FY 1985 for the purpose of implementing diabetic eye disease interventions; five were awarded to States holding current diabetes program cooperative agreements, and five were awarded to new States. These diabetic eye disease awards were for a 1-year period and the average award was $80,000.

The States receiving these awards were:

Colorado
Florida
Kansas
Kentucky
Maryland
Massachusetts
Minnesota
New York
Ohio
West Virginia

Mr. Early. Should the rescission for the diabetes State project grants be rejected, how many awards would be made in FY 1986, and how many of those would be new?

Dr. Mason. If proposed rescission funds were available for State projects, between 20 and 25 States could be funded. These awards could range from $80,000 to $250,000.

It is not yet possible to say how many of these would be new States, since this would be a competitive offering to all States. There would probably be some mix of old and new States, based on the technical quality of their applications.

LABORATORIES MONITORING AND TRACKING STD

Mr. Early. How many regional laboratories for monitoring and tracking sexually transmitted disease were to be opened prior to the sequestration order?

Dr. Mason. Eight laboratory and clinical testing sites were planned in FY 1986 as the initial phase of a comprehensive national program to monitor antibiotic resistance to gonorrhea. This program is part of the response to geometric increases in the number of antibiotic-resistant cases in each of the past 3 years. Although most of these have been penicillin-resistant cases, gonorrhea resistant to tetracycline and other commonly used antibiotics has been identified in several cities.

Mr. Early. Will these laboratories be opened in FY87? How many?

Dr. Mason. We currently project the opening of four regional sites in FY 1987.

Mr. Early. For the record provide a list of their locations.

Dr. Mason. In the first year, regional laboratory clinical testing centers are to be opened in Denver, Seattle, Baltimore, and Atlanta.

VACCINE STOCKPILE

Mr. Early. How will the sequestration of $172,000 impact the vaccine stockpile program?

Dr. Mason. The sequestration of $172,000 will not have a large impact on the stockpile. For example, if all of the sequestered funds were taken from the purchase of MMR vaccine, only about 20,300 doses would be deferred; this would represent less than 0.2% of the total target supply of MMR vaccine and would reduce the stockpile by less than a days supply.

Mr. Early. What time frame will the vaccine stockpile (at the post sequestration level) be able to cover, compared to the FY 86 enacted level?

Dr. Mason. Funds which have been appropriated through 1986 will provide the following percentages of a six-month stockpile. Contracts for these levels have been signed or will be signed during the year. As previously discussed, sequestration of the vaccine stockpile funds will have minimal impact.

DTP - 56.7 percent of target - 15 weeks
TOPV - 78.3 percent of target - 20 weeks
MMR - 56.7 percent of target - 15 weeks

Td - 69.8 percent of target - 18 weeks
DT - 59.0 percent of target - 15 weeks
IPV - 63.3 percent of target - 17 weeks

AIDS COOPERATIVE AGREEMENTS FOR HEMOPHILIA

Mr. Early. The justification mentions that CDC will also be using the AIDS cooperative agreement grants in order to establish a working relationship with local Hemophilia Treatment Centers. Will this be a requirement of receiving a cooperative agreement grant? What exactly are you doing in this regard? How much has been allocated for working with the hemophilia community?

Dr. Mason. The evaluation criteria in the Program Announcement for AIDS Health Education/Risk Reduction (HE/RR) cooperative agreement funds required that applicants provide evidence of a commitment to maintain close collaboration and working relationships with community-based organizations serving the interests of groups at risk for AIDS. Neither Comprehensive Hemophilia Treatment Centers nor any other specific organizations or entities serving high-risk individuals were singled out because it would have been impossible to catalogue all of the potential groups involved. Because the HE/RR programs are in a developmental phase at this time, it was not expected that many or all of the specific groups which ultimately will be involved in the polished program plan necessarily would be cited in the initial application document. This turned out to be the case; and while Hemophilia Treatment Centers were noted by some applicants, it was by no means unanimous. In the coming months CDC staff will be providing training and close technical assistance to key staff of cooperative agreement areas and will ensure that the CDC commitment regarding Hemophilia Treatment Centers receives appropriate attention.

In addition, CDC has set aside approximately $1.8 million to help support the comprehensive program to provide AIDS risk reduction education for hemophiliacs and the significant others in their lives. We are currently considering a proposal from the National Hemophilia Foundation that would provide an expanded array of services to this group.

AIDS AND OTHER STD

Mr. Early. Are the other sexually transmitted diseases suffering due to the amount of attention, in both dollars and staff, that has been shifted to AIDS?

Dr. Mason. A realistic part of the tradeoff of STD resources to perform AIDS related activities is a reduction in the amount of dollars and staff available for all but the most essential syphilis and gonorrhea disease intervention activities.

At this point, it is difficult to predict the overall effect of the diversion of STD resources to AIDS related activities, but the early reading is positive concerning the more traditional STD prevention and control activities. For example, in FY 1985 and thus far in FY 1986, the three States with the highest incidence of AIDS, California, New York, and Florida, have shown reduced levels of reported morbidity among gay males, despite increases in overall morbidity.

STD TRAINING

Mr. Early. Is the number of medical personnel receiving training in sexually transmitted diseases steadily increasing? How many received training in FY 85, what will it be in FY 86 and FY 87?

Dr. Mason. The number of medical and para-medical personnel trained has been increasing. For example, in FY 1985 2,619 clinicians attended formal training courses at STD Prevention/Training Centers (P/T centers), as compared to 1,170 who attended in FY 1980. Also in FY 1985, training for health care professionals who support or perform sexually transmitted disease intervention outreach activities was delivered to 269 Federal/State/local personnel.

In FY 1985, an estimated 7,500 health care professionals attended 44 1-day seminars delivered in 34 cities about "Serologic Testing for Antibodies to HTLV-III/LAV." In addition, about 1,100 public health staff were trained in a 2-day counseling course designed for personnel who would be counseling in alternative sites to test for antibody to HTLV-III/LAV. Thirty-five course sessions were delivered in 24 States by CDC instructors. Each course was attended by approximately 15 participants. It is estimated that State and local health department personnel, using the CDC curriculum and materials, delivered another 35-40 of these sessions.

In FY 1986 and FY 1987, it is anticipated that the total number of medical personnel receiving training will continue to rise because of the increased emphasis being placed upon such training at medical schools supported with special 318(b) funds. These projects will be in their final years of funding and should include all medical students at their respective locations.

Mr. Early. How much are you requesting for training activities in FY 87?

Dr. Mason. The amount requested will be $3.2 million. This includes personnel, grants for the support of 10 STD Prevention/Training centers and six medical school curriculum development projects, and support for the training of Federal/State/local personnel who manage, supervise, or perform disease intervention outreach activities.

STD CURRICULA IN MEDICAL SCHOOL

Mr. Early. What is being done to expand STD curricula in medical schools?

Dr. Mason. Six medical schools have received special 318(b) funds to develop STD curricula. We are following the experiences of these medical schools to determine their most successful approaches which will then be disseminated to all medical schools.

Second, we are now assessing all medical school programs in the United States to determine if they send medical students to STD clinics for training. If they do, we will evaluate the programs and, if necessary, suggest alterations. If they do not, we will encourage the development of a training program through State and local STD control programs. Moreover, we will share successful approaches from the curriculum development programs and provide proven teaching materials.

Third, in cooperation with the Association of Schools of Public Health, we are developing a practical manual for physicians for the diagnosis, treatment, prevention, and reporting of STD. When completed, the manual will be made available to all State and local programs for reproduction and distribution to students, physicians-in-training, and practicing physicians.

AIDS BUDGET

Mr. Early. Of the $203.482 million being requested for AIDS under the Office of the Assistant Secretary for Health, how much of that will be for CDC activities?

Dr. Mason. There is $45,409,000 included in the $203,482,000 for CDC.

Mr. Early. Of that amount how much is CDC planning to use for extramural activities, and how much for intramural activities?

Dr. Mason. Approximately $28.6 million will be used for extramural activities and $16.8 million for intramural activities.

AIDS FTE

Mr. Early. How many FTEs will be associated with the intramural portion?

Dr. Mason. Approximately 168 FTEs are associated with the intramural portion of AIDS activities.

AIDS ALLOCATION

Mr. Early. What portion of the FY 87 AIDS money will be allocated to ongoing commitments? What portion will be for new activities? What portion will be for the expansion of current activities.

Dr. Mason. Of the $45.4 million available for AIDS activities in FY 1987, $31.5 million will be allocated to ongoing commitments, $13.9 million will be used for the expansion of current activities.

Mr. Early. What portion of the FY 87 requested amount for AIDS (both in your request and the portion of the OSHA budget for CDC) reflects funds that have been redirected or reprogrammed from other areas not originally identified as "pure AIDS" areas?

Dr. Mason. Of the funds requested for AIDS activities in FY 1987, none have been redirected or reprogrammed from other areas not originally identified as "pure AIDS" areas. Although funds requested in FY 87 will augment our AIDS efforts, we anticipate continued diversion of about $6.8 million and about 45 FTEs in STD resources for AIDS related activities. These resource commitments are expected to continue benefitting overall STD program goals.

REDIRECTED AIDS

Mr. Early. Provide for the record a table showing the amounts and number of FTE's that have been redirected to AIDS activities from other program areas for FY 82 through FY 85. Also, include any amounts you plan to redirect in FY 87.

Dr. Mason.

FTE Redirected to AIDS Activities

FY	FTE
1982	11
1983	60
1984	44
1985	87
1986	106

CHLAMYDIA

Mr. Early. For the past several years this Committee has recommended increased support for the prevention and control of chlamydia. What was done to respond to this Congressional request in FY 1986 and what will be done to increase support in FY 1987?

Dr. Mason. The CDC has continued to expand its activities related to chlamydia prevention and control. Grant dollars expended in FY 1985 were more than double that of FY 1984 ($4.4 vs $2.1 million). In FY 1986 and FY 1987 approximately $4.5 million and $4.6 million respectively in grant funds will be devoted to chlamydia control. Control strategies with the most cost benefit to be emphasized within the limit of available resources include: (1) the use of erythromycin for eye prophylaxis in newborns to prevent both gonococcal and chlamydial ophthalmia neonatorum; (2) screening of high-risk pregnant women for chlamydial infection and treating cases and their sexual partners early in pregnancy; (3) selective screening of high-risk, nonpregnant women, particularly those who would not be receiving antichlamydial therapy in STD clinics and other facilities which care for sexually active people; (4) counseling and sex partner referral to assure the medical examination of sex partners as soon as possible; (5) completion of special 318(b) demonstration projects to identify the most efficient ways to improve diagnoses, simplify treatment, and to efficiently bring those groups which transmit a large proportion of chlamydial infections to examination; (6) incorporation of information on the recognition and management of clinical syndromes commonly caused by *Chlamydia trachomatis* into all appropriate programs of medical education and training; (7) treatment of chlamydial infections which frequently coexist with gonococcal infections by employing a gonorrhea treatment regimen effective against both organisms; and (8) treatment on the basis of clinical syndrome alone of women who have purulent cervicitis, urethritis, or salpingitis and men who have urethritis or epididymitis with antibiotics effective against both N. gonorrhoeae and C. trachomatis.

Mr. Early. How many new cases of chlamydia occur each year? How many babies each year are infected with chlamydia? How many teenagers get chlamydia each year?

Dr. Mason. Recent data indicate that an estimated 4 million new chlamydial infections occur in the United States each year, making it the most common sexually transmitted bacterial pathogen in the United States. Each year almost 247,000 chlamydial infections occur among infants. Teenagers, especially female teenagers, are at highest risk of chlamydial infection. Most published data indicates that rates among teenagers are 2-3 fold higher than any other group.

Mr. Early. What role does chlamydia play in the rate of infertility among women in this country? How many women become infertile each year due to sexually transmitted diseases?

Dr. Mason. Chlamydia is felt to play an important role in causing infertility due to blockage of the fallopian tubes. Nationwide estimates of the number of women made infertile are not available, but about half of all cases of fallopian tube infection are related to chlamydia.

Mr. Early. CDC recently published recommendations for preventing and controlling chlamydial infections. What efforts are being made, and how much money made available, to carry out the program recommended by the report?

Dr. Mason. Policy guidelines for the prevention and control of Chlamydia trachomatis infections were published in August of 1985. In FY 1985, grant funds devoted to developing programs recommended in these guidelines more than doubled from $2.1 to $4.4 million. In FY 1986, we anticipate that this figure will increase slightly to $4.5 million. It was CDC's intention to expand much more aggressively in FY 1986 but cuts required by Gramm-Rudman-Hollings have required concentration on a more limited number of priority activities.

AIDS AND CHLAMYDIA CONTROL

Mr. Early. To what extent has the diversion of funds for AIDS limited our efforts in chlamydia control? Aren't we just trading lives for lives? Chlamydia is a disease with severe consequences for women and their babies. Are you really willing to continue postponing efforts to do anything significant about the problem?

Dr. Mason. The effect on chlamydia of diversion of STD funds for AIDS related activities is minimal. Although AIDS is certainly life threatening, you are correct in your assessment of the serious personal and public health consequences of chlamydial infection. For this reason, CDC continues to place high priority on the development of a nationwide chlamydia prevention and control program. As indicated earlier, the rate of expansion will be somewhat hampered by the cuts required by Gramm-Rudman-Hollings.

TRAINING ACTIVITIES CARRIED OUT BY ERCs

Mr. Dwyer. In your opinion, does the Federal government have a responsibility in helping to support the occupational health and safety training activities carried out by the regional ERCs?

Dr. Mason. It is the Administration's belief that continued support for the ERCs should come from those non-Federal sources who benefit directly from the employment of those occupational safety and health professionals who received academic or continuing education training from the ERCs.

Mr. Dwyer. Last year the Committee urged in report language that the mission of the Educational Resource Centers be expanded to include research and research training in addition to their ongoing practitioner training activities. What is your view of such a merger of successful training and innovative research in occupational health and safety through the Educational Resource Center mechanism?

Dr. Mason. Expanding the ERCs to include research and research training would substantially contribute to efforts to prevent occupational disease and injury. It would ensure that students supported by ERCs are trained to recognize and evaluate occupational safety and health problems at the fundamental level. It would add new minds, resources, and efforts to the research on preventing occupational safety and health problems. Furthermore, it would assist the ERCs in competing with other university components for university and outside funds, helping ensure the continuation and growth of these programs for training scientists and professionals to work in occupational safety and health.

It should be emphasized that the Administration does not believe that continued Federal support of the ERCs as a training mechanism is a high priority, given the need to constrain Federal spending in areas where alternative sources of support are more appropriate at this time. However, faculty and students of these ERC centers are eligible to apply for Federal support of extramural research project grants and contracts in occupational safety and health from NIOSH.

CHLAMYDIA TEST

Mr. Hoyer. Your justification notes that there is no inexpensive, simple, and reliable lab test for chlamydia. Why is that?

Dr. Mason. Until recently the only reliable test for the diagnosis of chlamydial infections was the very expensive cell culture. The recent marketing of direct smear and ELISA tests for chlamydia has provided a relatively inexpensive, but slightly less accurate, test for the diagnosis of chlamydia when compared to the cell culture. For a chlamydia test to be practical for prevention and control purposes, however, it must also be inexpensive and accurate when used as a screening test. While the new tests have reduced the cost of diagnosis considerably, they still are too expensive to be practical for screening.

Mr. Hoyer. What are the prospects for developing one?

Dr. Mason. Researchers, including those at CDC and NIH, are continuing their efforts to develop improved diagnostic techniques for chlamydia. In addition, laboratory diagnostics is an extremely competitive field. As more and more State and local health departments add chlamydia prevention and control programs, the law of supply and demand should assure the development of less expensive yet highly accurate technology.

STD INCIDENCE

Mr. Hoyer. As your justification points out, the incidence of STD(s) seems to be generally decreasing. There are, however, pockets or areas of this country which still have unacceptably high levels of disease. Baltimore, for instance, is, I believe, number one in the number of gonorrhea cases. What's being done in these areas and why do these pockets remain?

Dr. Mason. It is true that many large cities, including Baltimore, have higher rates of sexually transmitted disease than the country taken as a whole. In 1985, Baltimore had a gonorrhea case rate of 2,465/100,000, or almost 7 times the U.S. rate of 358/100,000. The District of Columbia had a somewhat higher rate than Baltimore: 2,548/100,000. Generally, the sexually transmitted disease rates in an area parallel the rates for other infectious and chronic diseases as well as the rates for low income. Most of this phenomenon is real--illness follows poverty--but part of it is an artifact, since lower income persons utilize public clinics where the official reporting of disease is far more complete than it is in private physicians' offices.

CDC assigned employees, who assist with sexually transmitted disease control activities in State and local health departments, are almost always located in the areas with the highest levels of reported disease. These assignees are engaged daily in a wide range of program management, disease screening, and patient followup activities. In addition, disease trends are monitored weekly through reports to CDC's *Morbidity and Mortality Weekly Report*. Sharp, unexplained increases prompt inquiries to the State or local public health authorities. Advice and consultation regarding appropriate control measures can often be given by telephone. State or local authorities frequently request that an outbreak investigation be performed by CDC personnel so that targeted and comprehensive recommendations can be formulated. Occasionally a temporary reassignment of all available STD personnel to the affected area may be necessary.

INFECTIOUS DISEASES/TUBERCULOSIS

Mr. Hoyer. The budget for this account has been cut severely. Most of it is due obviously to the transfer of AIDS(s) funds. However, there is also a rescission request for $16.7 million. What programs or activities are included in this amount?

Dr. Mason. The proposed rescission for infectious diseases include the following programs: TB grants of $4,785,000, 24 hour AIDS hotline of $1,914,000, and AIDS alternate test sites of $9,934,000.

Mr. Hoyer. Your budget again eliminates TB grants. This also continues to be a health hazard in Baltimore and several other cities. How many grant requests were there for the FY85 funds? FY86?

Dr. Mason. There were 48 grant requests for Fiscal Year 1985 from 35 States, 11 major metropolitan areas, Guam, and Puerto Rico. Announcement of availability of Fiscal Year 1986 funds has not been made, pending a decision on the Administration's rescission proposal.

Mr. Hoyer. Was there enough money to fund all the requests?

Dr. Mason. In Fiscal Year 1985, applicants requested $8,989,643. This was more than our appropriation of $5,000,000.

Mr. Hoyer. According to your justification on page 39 there is an increase in tuberculosis cases. But the following statement is also made: "...outbreaks of tuberculosis among the homeless may be contributing to the leveling off in tuberculosis morbidity." Is there a connection between AIDS and tuberculosis?

Dr. Mason. Actually the number of cases did not increase nationally, they declined, but at a slower rate than in previous years. Although the reasons for the relatively small decline in 1985 cases are not fully known, evidence supports the hypothesis that human T-lymphotropic virus type III/lympha-denopathy-associated virus (HTLV-III/LAV) infection of persons infected with the tubercle bacillus has caused an increase in tuberculosis in some areas.

The suspicion that HTLV-III/LAV infection may be responsible for increased tuberculosis morbidity is based on the following:

1. Since other immunosuppressive disorders are associated with an increased risk of developing clinically apparent tuberculosis, there is a theoretical reason to believe that compromised immunity secondary to HTLV-III/LAV infection may favor activation of preexisting latent Mycobacterium tuberculosis infection.

2. Some of the areas with the largest tuberculosis morbidity increases this year, New York City, California, and Florida are also some of the areas that have reported the largest number of acquired immunodeficiency syndrome cases to date.

3. Data from New York City indicate that increased tuberculosis morbidity is occurring in areas of the city where most AIDS cases have occurred. Matching the New York City register of reported tuberculosis cases with the AIDS case register has revealed increasing numbers of AIDS patients with histories of tuberculosis. An

increasing number of persons with histories of intravenous drug abuse--a known risk factor for AIDS--have been diagnosed as having tuberculosis.

4. In Dade County, Florida, a substantial number of persons with AIDS either had tuberculosis at the time AIDS was diagnosed, or had it within the 18 months preceding the AIDS diagnosis. Based on an analysis currently in progress, 109 (10.0%) of the 1,094 AIDS patients reported to CDC from Florida through December 31, 1985, have also been diagnosed with tuberculosis.

CDC epidemiologists and tuberculosis program personnel are working closely with health departments in Florida and New York City on studies to better define and understand the tuberculosis/AIDS/HTLV-III problem and to design the most effective and efficient control strategies.

ELIMINATION OF TB GRANTS

Mr. Hoyer. That being the case, is this a good time to eliminate TB grants?

Dr. Mason. State and local governments have traditionally assumed the responsibility for most of the costs of prevention and control of tuberculosis in the community. We believe many States will allocate Preventive Health Block Grant or other funds for cost effective tuberculosis control activities that are now funded by our program. Most State and local health departments, particularly those with significant tuberculosis problems, recognize the need to keep the disease in check. Experience with the Tuberculosis Cooperative Agreements since 1982 has demonstrated the effectiveness of intensified prevention and control activities in many high incidence areas. Some areas have reported substantial cost savings because noncompliant patients who previously needed to be hospitalized for treatment of tuberculosis can now be treated successfully as outpatient. Based on the experiences in using Tuberculosis Cooperative Agreement funds, the States are now in an excellent position to evaluate funded activities and determine where they rank among the other priorities of the States. We are convinced that many States will want to continue applying the outreach technologies developed through the grant where they have proven to be cost effective versus the alternatives of continued community spread or costly long-term hospitalization of noncompliant patients.

In general, we believe that the block grant approach is the most effective way for the Federal Government to assist States in addressing public health and other problems. This approach is consistent with the Administration's commitment to balance the budget. Block grants permit States to establish their own priorities and to direct funds to those problems which they perceive to be the most urgent.

The 1987 budget request for the Refugee Preventive Health program (in the Office of Refugee Resettlement) is $10.3 million, an increase of $2.3 million over the 1986. Funds from this program are available to State and local agencies for TB control, therapy, and follow-up for those refugees identified as being TB-infected and eligible for preventive treatment.

BLACK AND MINORITY HEALTH NEEDS

Mr. Hoyer. What has CDC planned in FY 87 to respond to the Secretary's Task Force Report on Black and Minority Health needs?

Dr. Mason. Since surveillance and the gathering of epidemiologic information are central to CDC's activities, its programmatic efforts in prevention consistently are directed toward populations at highest risk for the leading causes of death, disease, and disability. Consequently, black and other minority populations constitute a substantial proportion of those who receive services through programs directly or indirectly influenced by CDC. The Task Force Report identifies excess mortality in a number of areas--e.g., infant mortality, chronic diseases, intentional and unintentional injuries. CDC activities address all of these issues.

In addition to CDC's traditional activities, many of our health promotion and environmental health efforts have been and will continue to be targeted toward minority populations. For instance, our study of an exercise program among Zuni Indians, whose rate of non-insulin dependent diabetes is almost twice that of other adults in this country, has shown that community based exercise programs in this minority population can be effectively implemented, and can contribute to significant weight loss and a reduction in hypoglycemic agent dependency. Injuries are a major problem for minorities, and CDC has programs addressing such issues as injury control among populations with substantial proportions of Hispanics, surveillance of homicides among young Blacks and Hispanics, and a study of family assaults in a largely black population.

CDC has launched a smoking and pregnancy pilot project that is specifically directed toward low income women, and this will make a substantial contribution toward improving infant morbidity and mortality outcomes. We have requested an additional $1.7 million for FY 1987 to support infant mortality activities designed to help ensure that infants have a healthy start in life and reduce the disparity in rates of infant mortality and low birthweight between blacks and whites. Our nutrition surveillance activities focus on the nutritional status of low-income children and pregnant women, and separately monitor black, Hispanic, and Southeast Asian refugee populations. CDC is developing Community Intervention Guides, some of which will be available in 1987, that address important risk factors among minority and underserved populations. Of course our school health initiatives provide young people with preventive learning opportunities of proven effectiveness, irrespective of racial or ethnic status.

To further address the concerns identified in the Report, CDC staff has met with the Director of PHS's new Office of Minority Health, Dr. Herbert Nickens, to discuss these activities, and ways that new work might be begun collaboratively with that office.

NUTRITION MONITORING PLAN

Mr. Hoyer. Is the National Nutrition Monitoring Plan part of the response?

Dr. Mason. The health and nutritional status of blacks and minorities is, of course, of vital concern to us. CDC activities are aimed primarily at the evaluation of nutritional status in order to provide necessary information for nutrition program and policy decisions in the States. While the kinds and degrees of malnutrition vary from place to place and are present among all ages, ethnic groups, and socioeconomic levels, the major nutrition-related problems are more prevalent in the very young, minority group individuals of low socioeconomic status, the aged, and pregnant women. The problems consist primarily of growth deficit, obesity, and nutritional anemias.

CDC will continue to work with State and local health departments to further the development of a nutrition surveillance system which has the capability to focus on highly vulnerable populations (e.g., high-risk black and minority pediatric and prenatal patients) throughout the United States.

The system, which is designed to monitor continuously the nutritional status of these populations, is based on information collected routinely in service delivery programs such as WIC and MCH. The information consists primarily of measurements such as height, weight, hemoglobin and/or hematocrit, and birth weight. Data are rapidly analyzed and comparisons are made with reference population data in order to characterize the nutritional status of the population from which the data are gathered. The information is then returned through the State health department to the service delivery source for immediate use in program planning, management, and evaluation of health resources at both the State and local level. The Pediatric Nutrition Surveillance System presently has 34 State participants who submit approximately 1.9 million records per year to CDC. Seventeen States participate in the Pregnancy Nutrition Surveillance System and submit records on approximately 93,000 pregnancies per year.

CHRONIC AND ENVIRONMENTAL DISEASES

Mr. Hoyer. How will the Chronic and Environmental Diseases program be affected?

Dr. Mason. Chronic and environmental diseases contribute much to our health care costs as well as human suffering, despite the fact that we know much today about how to prevent them. We think that a concerted attack, using all the tools available, can have significant impact on the burden of illness of all Americans. As the Task Force Report documents, this is especially so for blacks and other minorities, who have excess mortality in such areas as infant mortality, injuries, and chronic conditions.

Our comprehensive public health approach includes health promotion and health protection, to reduce risk factors and hazardous exposures, and prevent disease from ever occurring. In addition, we are devoting attention to preventive health services to help detect and control diseases early in their course. This can be seen in cervical cancer, where we are working with the State of Kentucky to improve pap smear use and reduce cancer deaths. It can be seen in smoking and pregnancy, where we will soon begin a pilot test in a State to integrate smoking cessation into public prenatal clinics for low-income groups, to reduce infant mortality. It can be seen in community-based and school-based health education programs, where we can now show impressive improvements in both knowledge and health practices as a result of good programs, and an increase in State prevention block grant commitments to health promotion efforts. All of these efforts are especially relevant to minority health.

Cardiovascular disease, in particular, strikes blacks in excess; moreover, as the leading cause of death in the U.S., it is a key preventable problem for Americans of all races. Over the next two years, CDC will seek to improve the impact of State efforts to prevent heart disease and stroke. A recent CDC analysis of premature cardiovascular disease deaths indicates that 30% are the result of smoking, 18% elevated blood pressure, and 9% elevated serum cholesterol--more than half is attributable to these three preventable causes alone. We believe the burden of this illness can be shown to be significantly reducible if a community can do several things in concert--that is, to help people to stop smoking, to help people with high blood pressure or cholesterol to know their status and to take steps to lower it, and to help the general population to control weight, to exercise, and to eat less fat in their diet. Since cardiovascular disease is so significant a problem among blacks, such efforts on our part will include specific effort to document the effects of the program on black health status.

NEW INITIATIVES

Mr. Hoyer. Your justification mentions two new initiatives, the Pregnancy Nutrition Surveillance System (PNSS) and the Behavioral Risk Factor Surveillance System (BRFSS). How will these initiatives work on the local level?

Dr. Mason. A basic need exists at both the State and local levels for a mechanism which can identify both those women most at risk for poor pregnancy outcome and monitor alterable health risk behaviors, such as smoking or heavy alcohol use, which can contribute to poor pregnancy outcome. Two mechanisms currently exist, which with significant enhancement, can adequately address the State and local need for this information. The Pregnancy Nutrition Surveillance System, coordinated by CDC, presently collects nutrition-related information on high-risk pregnant women who attend publicly-supported clinics in 17 States. Information on birth outcome and the condition of the infant at the time of the 6-week postpartum examination is also collected. However practical difficulties, the linking of clinic visit information with birth outcome and postpartum information for example, is a major reason for the limited reporting. States have only just begun to realize the benefits of monitoring low-income pregnant women and the risk factors associated with poor pregnancy outcome. The proposed initiative would enable this system to be expanded geographically to new States and to those local areas within States not presently monitored.

Capability to assess the prevalence of behavioral risk factors in the adult population now exists in 26 States. A number of the risk factors which are addressed, such as smoking, alcohol use patterns, and weight status, have been shown to be associated with poor pregnancy outcome. This capability will be augmented to permit increased collection of data relevant to pregnant women through new sampling procedures and through technical assistance in data analysis and interpretation provided through State and local workshops and data feedback. The end result will be a reduction of premature death and preventable morbidity in high-risk populations resulting from intervention efforts directed to those areas and groups of people in greatest need.

Mr. Hoyer. With only $1.75 million for these two programs, how extensive or widespread will they be?

Dr. Mason. The intent of the initiative is to enhance State capacity for monitoring risk factors associated with poor pregnancy outcome (i.e., low birth weight) and, thereby, reduce preventable morbidity and mortality among high-risk women and children. The initiative will build on the established network of State health department/CDC relationships.

The technical augmentation will include the expansion of risk factor data collection and technical assistance to States in data analysis and interpretation. As a result, these States will be able to furnish needed data to those who make policy and program decisions relative to maternal and child health and nutrition at the State and local level.

The program to expand epidemiologic capacity of States' maternal and child health departments will consist of assigning a limited number of CDC epidemiologists to work with States. We believe these efforts to augment State analytic and data capability will permit improved effectiveness and efficiency in these State programs.

Mr. Hoyer. If they are limited to selected areas of the country, what can I do to convince you to come to Prince George's County, Maryland?

Dr. Mason. The traditional and successful role of CDC, namely providing capacity-building expertise to the States, is at the core of this initiative. The intent is to build on the established network of State health department relationships which underlie the surveillance mechanisms addressed by the initiative and which, when properly augmented, will furnish needed data to policy and program decision-makers.

Unfortunately, Maryland, at the present time, is not a participant in either the Pregnancy Nutrition Surveillance System or the Behavioral Risk Factor Surveillance System. CDC has a smoking/community intervention assignee at the Maryland Department of Health and Mental Hygiene which will benefit many State and county programs. The importance of smoking to the incidence of low birthweight and subsequent infant mortality is well understood, and there will be particular benefit from this additional assistance.

TB COOPERATIVE AGREEMENTS

Mr. Hoyer. Dr. Mason, can you tell us how well the Tuberculosis Cooperative Agreement Program is working?

Dr. Mason. The TB Cooperative Agreements have had some very beneficial results. In 1985, Cooperative Agreements were awarded to health departments in 35 States, 11 major metropolitan areas, Guam, and Puerto Rico. These funds have been used primarily to demonstrate the effectiveness of hiring community outreach workers to provide directly observed therapy to infectious and potentially infectious patients unable or unwilling to complete the treatment to make them noninfectious. An estimated 10 percent of all new tuberculosis patients are now being treated with directly observed therapy. Prior to this program, virtually no outreach directly observed therapy was used in this country despite the fact that CDC had been recommending its use for over ten years.

This comparatively small program is resulting in substantial tuberculosis hospitalization savings. For instance, reports from Connecticut, Los Angeles, and Massachusetts indicate annual savings of $81,000, $1,950,000, and $950,000 respectively through the use of outpatient and directly observed therapy instead of hospitalization for noncompliant patients. Although it varies from State to State, it is estimated that 25 to over 50 percent of these tuberculosis hospitalization costs would have been paid by Medicare/Medicaid.

TUBERCULOSIS CASE RATE

Mr. Hoyer. During 1985 there were almost as many TB cases reported as in 1984. I know that CDC, through these cooperative grants to state and local health departments, is doing more now than it has in past years to control TB. Yet we are now seeing a slowing of the decline in tuberculosis rates than we have enjoyed in the last four to five years. Do you think this leveling off of reported TB cases is a result of better reporting, and perhaps that the tuberculosis outreach workers who are working in communities are discovering more cases of TB as they monitor and encourage TB patient drug therapy compliance and rehabilitation?

Dr. Mason. While the slowing in the decline in TB rates may be in part due to increased surveillance efforts as the result of the Cooperative Agreements, we are very much concerned about the leveling off of the downward trend in the incidence of tuberculosis in the United States and we are looking closely into the problem. The provisional total of 21,801 tuberculosis cases reported for 1985 (case rate of 9.3 per 100,000 population) represents only a 2 percent decrease from the 22,255 cases reported in 1984. During the previous three years, tuberculosis morbidity had declined an average of 6.7 percent.

Although the reasons for the relatively small decline in the number of 1985 cases are not fully known, we have reason to believe that human T-lymphotropic virus type III/lymphadenopathy-associated virus (HTLV-III/LAV) infection of persons infected with the tubercle bacillus has caused an increase of tuberculosis in some areas. CDC epidemiologists and tuberculosis program personnel are working closely with health departments in Florida and New York City on studies to better define and understand the tuberculosis/AIDS/HTLV-III problem and to design the most effective and efficient control strategies.

PREVENTION CENTERS

Mr. Hoyer. Dr. Mason, one of the primary responsibilities of the CDC is prevention. You have proposed to rescind $1.5 million which Congress appropriated for CDC prevention centers.

Why have you requested this rescission?

Dr. Mason. The rescission is proposed as part of the President's overall budget reform plan to curtail Federal Government spending.

Because of the overriding need for Federal fiscal constraint, it is difficult to justify starting new programs, such as prevention centers, at this time. CDC currently spends about $1 million a year on cooperative agreements and contracts for similar research and demonstration projects on health promotion and disease prevention. In addition, over $1.2 billion are spent each year by other Federal biomedical research agencies on prevention research activities.

CENTERS FOR HEALTH PROMOTION AND DISEASE PREVENTION

Mr. Hoyer. If this subcommittee does not approve this rescission what are your plans to establish Centers for Health Promotion and Disease Prevention this year?

Dr. Mason. If the proposed rescision is rejected by the Congress, we would publish in the Federal Register an announcement to request applications.

Mr. Hoyer. How many are you going to set up and how soon?

Dr. Mason. After our review, we would award funds to the top rated three or four applicants, probably in September 1986.

DIABETES CONTROL PROGRAM

Mr. Hoyer. If the CDC does not continue to fund the Diabetes Control Project at about $7.5 million, there will be a serious reduction in this already limited program. Much of the national effort to control diabetes will be lost. What justification is there for the elimination of this program?

Dr. Mason. This program was designed as a 5-year demonstration program. During its 5 years, the program has proven successful in developing methodology to reduce complications of diabetes and in developing State self-sufficiency. In FY 1984, four to five States made in-kind contributions of approximately $3.5 million, to support the State diabetes control programs while 15 other States contributed a total of $1 million. Other States have been successful in obtaining third-party reimbursement for diabetes patient education programs.

ECTOPIC PREGNANCY

Mr. Conte. What is an ectopic pregnancy?

Dr. Mason. An ectopic pregnancy is a pregnancy that implants somewhere other than in the cavity of the uterus. The most common ectopic site is the fallopian tube.

Mr. Conte. How many occur each year, and how many of these are caused by sexually transmitted diseases?

Dr. Mason. Approximately 60,000 to 70,000 ectopic pregnancies occur each year, and about half of these can be linked with sexually transmitted disease.

Mr. Conte. What do you think will happen to these this year given the increase in gonorrhea?

Dr. Mason. The impact of increased rates of gonorrhea on the incidence of ectopic pregnancy cannot be accurately predicted. Given no changes in treatments, increased rates of gonorrhea lead to increased rates of infection of the fallopian tubes. As a result, rates of ectopic pregnancy can reasonably be expected to increase.

Mr. Conte. I understand that ruptured ectopic pregnancy is now the leading cause of maternal death among black women. What are we doing about that?

Dr. Mason. Ectopic pregnancy is a leading, but not the leading, cause of maternal death among black women. CDC is conducting epidemiologic investigations of all such deaths in an effort to identify preventable causes. Several publications have resulted from this research. Traditional gonorrhea, and more recently chlamydia prevention and control activities, also seek to reduce the number of ectopic pregnancies.

REPORTING CHLAMYDIA

Mr. Conte. Why isn't chlamydia a reportable disease in every State?

Dr. Mason. At the present time, there are no inexpensive, simple and reliable diagnostic tests for *Chlamydia trachomatis*. Historically, time consuming and expensive tissue-culture techniques have been required to definitively diagnose most *C. trachomatis* infections. In recent years, antigen detection methods have become available although there is still some concern about their reliability, particularly in field settings. In short, laboratory capability for diagnosing *C. trachomatis* is emerging but is still far from ideal. Since laboratory confirmation of *C. trachomatis* is so difficult and expensive, most are treated on the basis of symptoms/syndromes and States have been understandably reluctant to require reporting.

Mr. Conte. How many States have laws or regulations making chlamydia reportable?

Dr. Mason. At the end of fiscal year 1985, 17 States had laws or regulations making Chlamydia trachomatis and/or chlamydia-related conditions reportable.

Mr. Conte. Are you working to bring the other States into reporting status?

Dr. Mason. States have been encouraged to require reporting of chlamydia-associated disease and to transmit appropriate surveillance data since January 1984, when CDC implemented a surveillance system for collecting and monitoring reported cases of chlamydial infection for males and females by each State. This system will require State reporting laws and/or regulations to provide the necessary support for prevention activities. Reporting laws promote and legitimize the involvement of public health authorities in assuring adequate individual patient management--including referral of sex partners--and may facilitate other activities such as screening and education. Moreover, case reporting provides a uniform basis for describing the extent and trend of disease.

AIDS

Mr. Conte. Centers for Disease Control, why is it that people who have received blood transfusions are not considered high risk for AIDS?

Dr. Mason. Millions of persons have received blood transfusions in the period 1981-1986, but only a very small number of them have actually been reported with AIDS (288 AIDS cases in adults and 40 in children, or approximately 2 percent of all cases reported as of March 24, 1986). Screening of donated blood and plasma, implemented in 1985, coupled with voluntary self-exclusion of members of high-risk groups, will further reduce the risk of AIDS virus infection to those receiving transfusions. Although transfusion recipients do have a higher risk for AIDS than other members of the "general public," their risk is much lower than for gay men, intravenous drug abusers, and persons with hemophilia.

Mr. Conte. Centers for Disease Control, should this group be encouraged to take the AIDS blood test?

Dr. Mason. The Public Health Service has not specifically recommended that transfusion recipients take the AIDS blood test. However, previously transfused persons may wish to be tested, particularly if they could potentially transmit the infection to others.

Mr. Conte. Centers for Disease Control, do these people represent the chance of further spread of the disease?

Dr. Mason. The number of persons previously infected with the AIDS virus through transfusion is throught to be relatively small. However, persons infected through this route could potentially infect their sexual partners, and infected pregnant women could transmit the virus to their infants.

DTP VACCINE

Mr. Conte. The other day I talked with the Director of the Institute on Allergies and Infectious Diseases about a trial they're doing on a new DPT vaccine in Sweden. Are you involved in that trial in any way, or are you doing some work on your own to develop a safer DPT vaccine?

Dr. Mason. CDC has provided technical and financial support for the planning of the National Institutes of Allergy and Infectious Diseases sponsored trial in Sweden and is continuing to provide technical assistance in overseeing the trial in collaboration with NIAID and FDA scientists. CDC is not sponsoring any vaccine development efforts, nor are we directly involved in such efforts. CDC is involved, however, in related projects to improve diagnosis, better understand the epidemiology, and better assess the risks of vaccination.

Mr. Conte. Right now there are only two manufacturers of the current DTP vaccine in this country. Is that correct?

Dr. Mason. No, currently there are five manufacturers of DTP. However, two are States (Michigan and Massachusetts) and distribution is limited to providers within those States. Wyeth is also manufacturing DTP for Lederle via contract. Connaught and Lederle are the only two manufacturers which are producing and distributing DTP nationally.

Mr. Conte. Why are we having difficulties getting legislation passed to correct the problems of insurance in this area?

Dr. Mason. As you know, considerable progress was made early last year in identifying the problems, reviewing alternatives, and developing legislative proposals. Most of this progress was made because of the shortage of DTP vaccine. However, following the meeting and deliberations of the Working Group on Vaccine Supply and Liability, Connaught Laboratories announced that it had worked out insurance arrangements and was resuming full distribution of DTP vaccine in the United States. As a result of those developments, many people thought the vaccine supply problem had been solved. Unfortunately, the root cause driving the problem of vaccine supply and cost-liability-remains, and must be addressed before additional vaccine suppliers decide to withdraw from the market in the United States.

CURRENT STATUS OF VACCINE STOCKPILE

Mr. Conte. What is the current status of the nation's vaccine stockpile?

Dr. Mason. Funds have been appropriated through FY 1986 which will provide an aggregate 17-week supply of the major childhood vaccines in the stockpile, compared to the goal of a 6-month (26 week) supply. Individually, by vaccine, the following supplies are expected to have been accumulated by the end of FY 1986:

OPV - 20 weeks (78.3% of goal)
DTP - 15 weeks (56.7% of goal)
MMR - 15 weeks (56.7% of goal)
Td - 18 weeks (69.8% of goal)
DT - 15 weeks (59.0% of goal)
IPV - 16 weeks (63.3% of goal)

Contracts for these levels have been signed or will be signed during the year. Each contract calls for a phased delivery of vaccine to the stockpile, based on production capabilities and the need for normal vaccine deliveries to the public and private sectors.

FUNDING FOR VACCINE STOCKPILE

Mr. Conte. Why are you requesting no funds for the stockpile in FY 1987?

Dr. Mason. While bringing the stockpile up to an optimum 6-month supply remains a priority, several issues are now being considered in the area of vaccines that make it appropriate to delay further expansion of the stockpile for now. First, the Administration has transmitted legislation to the Congress to ban, except for negligence, punitive and limit non-economic damage awards against vaccine manufacturers to help ensure that these companies can obtain liability insurance. Second, new vaccines for DTP are being developed which are likely to replace the vaccines currently in use. Third, an additional manufacturer of OPV vaccine is expected to enter the market, and it is possible that a second company may be considering entering the MMR vaccine market. We expect that expansion of the stockpile could be resumed in the near future if these issues are resolved and funds become available.

Mr. Conte. If we could get some legislation passed to correct the insurance problem, would you consider funding for the stockpile?

Dr. Mason. We hope that the conditions previously mentioned will allow us to continue building the stockpile in the near future. I feel passage of legislation to correct the insurance problems would relieve the majority of the concerns.

COST EFFECTIVENESS OF IMMUNIZATION PROGRAM

Mr. Conte. In general, how cost effective is the nation's immunization program?

Dr. Mason. In spite of the recent increase in the price of vaccines, immunization still has a high benefit-cost ratio. For example, the benefit-cost ratio of rubella immunization given in combination with measles vaccine is estimated to be over 14:1. The benefit-cost ratio for polio immunization is over 10:1 and for DTP about 3:1. This translates to an estimated savings of about $1 billion per year for polio, and $500 million per year for measles. Since 1963, over 59 million cases of measles, and 19,500 cases of mental retardation have been averted, and 5,900 children's lives have been saved as a result of measles immunization.

TUBERCULOSIS CONFERENCE

Mr. Conte. Last year your Agency conducted a conference on tuberculosis in my hometown of Pittsfield. What findings or recommendations came out of that conference?

Dr. Mason. A conference entitled "Future Research In Tuberculosis -- Prospects and Priorities For Elimination" was held in Pittsfield, Massachusetts, June 5-7, 1985. Co-sponsors of this conference were the Pittsfield Antituberculosis Association, the American Thoracic Society, the National Institutes of Health, and the Centers for Disease Control. The invited participants represented a wide variety of scientific disciplines, including biochemistry, epidemiology, immunology, microbiology, genetics, behavioral science, pulmonary medicine, pharmacology, public health, clinical infectious diseases, and pathology.

The objective of this conference was to identify priority areas for research which might lead to an accelerated decline in tuberculosis morbidity and, ultimately, to the elimination of tuberculosis from the United States and the World. In recent years, new developments in the basic sciences have led to improvements in the prevention, diagnosis, and treatment of many infectious diseases. However, many promising techniques and procedures have been only incompletely applied or studied in relation to tuberculosis. These new techniques and procedures include deoxyribonucleic acid (DNA) probes for rapid, specific detection of bacilli; serologic tests with monoclonal antibodies to detect antigens in body fluids; radiometric and cell culture procedures for rapid drug-susceptibility tests; development of new drugs and new drug delivery systems; behavioral modification techniques for improving patient compliance; new preventive therapy regimens based on a better knowledge of the characteristics of the infecting organisms and the host; and new vaccines based on a more thorough knowledge of how to modify the immune system. These and many other topics were examined in detail during the course of the conference in order to focus these newer methods and concepts on tuberculosis.

The Conference participants recommended further research and study in five areas: (1) improving methods for preventing infection of the uninfected; (2) improving methods for detecting infected persons at risk of developing disease; (3) improving methods for preventing disease among the infected; (4) improving methods for diagnosis of tuberculosis; and (5) improving treatment for tuberculosis. It was the Conference consensus that if these areas for future research were pursued in earnest, it would lead to a major expansion in our knowledge-base and to the development of better tools for controlling the disease. With the development and use of new tools in the field, the prospects for elimination of tuberculosis become brighter.

Mr. Conte. Is there a written report on that conference that you could submit to the Committee?

Dr. Mason. A report from the conference, "Future Research In Tuberculosis -- Prospects and Priorities For Elimination," has been received by the co-sponsors and is now ready for publication. A copy of this report will be submitted to the Committee.

SLOWDOWN OF DECLINE IN TB RATES

Mr. Conte. From what I've read, there's been a dramatic slowdown in the decline of TB in this country. Why is that and if it's true, why are you proposing to eliminate the TB control grants in FY '86 and why is there no new money proposed for '87?

Dr. Mason. There has been a slowdown in the decline of tuberculosis in the United States. We are very concerned about this and are looking into the problem. The provisional total of 21,801 tuberculosis cases reported for 1985 (case rate of 9.13 per 100,000 population) is a decrease of only 2.0 percent from the final tuberculosis case total for 1984. During the previous three years (1982, 1983, and 1984), tuberculosis morbidity declined an average of 6.7 percent.

Although the reasons for the relatively small decline in 1985 cases are not fully known, evidence supports the hypothesis that HTLV-III/LAV infection of persons infected with the tubercle bacillus has caused an increase in TB in some areas.

State and local governments have traditionally assumed the responsibility for most of the costs of prevention and control of tuberculosis in the community. We believe many States will allocate Preventive Health Block Grant or other funds for cost effective tuberculosis control activities that are now funded by the $5 million Tuberculosis Cooperative Agreements. Most State and local health departments, particularly those with significant tuberculosis problems, recognize the need to keep the disease in check. Experience with the Tuberculosis Cooperative Agreements since 1982 has demonstrated the effectiveness of intensified prevention and control activities in many high incidence areas. Some areas have reported substantial cost savings because noncompliant patients who previously needed to be hospitalized for treatment of tuberculosis can now be treated successfully on an outpatient basis. Based on the experiences in using the Tuberculosis Cooperative Agreement funds, the States are now in an excellent position to evaluate funded activities and determine where they rank among the other priorities of the States. We are convinced that many States will want to continue applying the outreach technologies developed through the grant where they have proven to be cost effective versus the alternatives of continued community spread or costly long-term hospitalization of noncompliant patients.

In general, it is believe that the block grant approach is the most effective way for the Federal Government to assist States in addressing public health and other problems. This approach is consistent with the Administration's commitment to balance the budget and keep inflation in check. Block grants permit States to establish their own priorities and to direct funds to those problems which they perceive to be the most urgent.

Additional funds are available in the Office of Refugee Resettlement. The budget request for 1987 includes $10.3 million, an increase of $2.3 million over 1986, for States and local agencies to control TB in refugees.

INFANT MORTALITY

Mr. Conte. Your justifications talk about a $1.7 million new Public Health Service Infant Mortality Initiative. What is this initiative?

Dr. Mason. There has been a great deal of interest expressed recently regarding infant mortality and low birth weight. This has centered around concerns that the rate of infant mortality decline has slowed, that there is a disparity in infant mortality rates between whites and blacks, and there is a lack of progress in reducing the incidence of low birth weight. This initiative builds upon recent PHS initiatives and activities and would facilitate the targeting of available resources so as to have the maximum impact.

This initiative will provide support for improved data collection, surveillance, and related research into the causes of and solutions to low birth weight. Low birth weight is associated with neonatal and infant mortality and adverse maternal health behaviors during pregnancy, such as alcohol misuse, cigarette smoking, and poor nutritional practices, contribute strongly to the condition. This initiative will enable States to better address this issue by identifying those populations at highest risk, enabling them to target intervention efforts, and provide resources for evaluating progress towards the 1990 objectives related to low birth weight.

By furthering the development and refinement of existing surveillance capability to address health risk factors in pregnancy, this initiative will significantly increase State capacity to monitor health-related behaviors associated with poor pregnancy outcome and to use the information to direct intervention efforts more precisely and efficiently to those areas and populations in greatest need. The anticipated outcome will be a reduction of premature death and preventable morbidity in highly vulnerable infant populations.

LOW BIRTHWEIGHT

Mr. Conte. Why are we seeing relatively no progress in reducing the incidence of low birthweight?

Dr. Mason. The incidence of low birthweight in the United States has declined only modestly during the past two decades. Factors that contribute to the incidence of low birthweight are numerous, complex, and often interrelated. These include extremes of maternal age, inadequate prenatal care, certain infections, unintended or unwanted pregnancy, poverty, lack of education, maternal illness, undernutrition, smoking and use of other harmful substances, personal history of previous reproductive complications, close birth spacing, and many others. Black women have an approximately two-fold risk of delivering a low birthweight infant compared to white women.

The relative importance of these various risk factors has fluctuated over the years. However, failure to effect more rapid advances in the reduction of low birthweight reflects two major factors; first, an inability to develop preventive approaches which comprehensively and effectively address the broad spectrum of medical, behavioral, environmental, economic, and social factors that contribute to the low birthweight problem and second, inadequate knowledge of the causes of premature delivery.

One of the leading known contributors to low birthweight, and one that is preventable, is cigarette smoking during pregnancy. It has been estimated that up to 25 percent of low birthweight in this country may be attributable to smoking. Groups of women who are already at high risk of delivering a low birthweight infant are often the groups that have the highest rates of smoking during pregnancy. This includes the lower socioeconomic status women who receive prenatal care services at public clinics. CDC has begun a pilot project to develop smoking cessation techniques that can be readily incorporated into routine prenatal services in public clinics.

While development and widespread dissemination of effective techniques in this area can contribute substantially to the effects to decrease low birthweight, other, more basic research, will also be needed to provide the base from which the next generation of public health interventions will be developed.

FUNDS DIVERTED FOR AIDS

Mr. Conte. During the hearings last year, Doctor, I asked you if you were diverting any money to AIDS from other programs. At that time you responded that funds would be diverted for the alternative testing sites, but that you would inform the Committee of any further diversion of funds. During FY 1985 and FY 1986, what sums were diverted from the sexually transmitted disease program to carry out AIDS activities?

Dr. Mason. During fiscal year 1985 an estimated $6 million in STD project grants and program operation funds were used to support various AIDS related activities. Although funds provided in fiscal year 1986 will augment our AIDS efforts, we anticipate continued diversion of approximately $6.5 million in STD resources.

AIDS AND OTHER STD ACTIVITIES

Mr. Conte. Which STD activities have been cut in order to carry out AIDS activities?

Dr. Mason. AIDS related activities in STD project areas involved staff and resources for various AIDS organizational, educational, and epidemiological activities. At CDC, they involved personnel who provided technical and management assistance to various State and local initiatives plus training staff engaged in projects such as alternate sites for HTLV-III/LAV antibody testing. CDC believes that the activities of these people relate to their other duties in STD control and that the commitment of resources to AIDS activities is to the short- and long-term benefit of STD control. Groups and individuals at increased risk for AIDS are also traditional constituencies served by the STD program. Program related activities directed toward reducing the risk of AIDS spread to and by such individuals have the identical impact on STD morbidity, a fact supported by the leveling off in some STD's and the decrease in others among gay men.

Mr. Conte. What specific responsibilities in AIDS control are now being carried out by the STD program?

Dr. Mason. Since the Division of Sexually Transmitted Diseases (DSTD) has the expertise needed, they have been assigned responsibility for certain AIDS activities in the States and have been provided AIDS funds and FTEs. DSTD at CDC oversees 6 AIDS health education cooperative agreements and 4 community-based AIDS HE/RR demonstration projects. Shortly these will be expanded to include approximately 35 capacity-building, 20 augmentation, 2 additional demonstration, and up to 8 innovative risk reduction cooperative agreements. DSTD is also responsible for a contract to develop a set of common data items which will be used to assess levels of AIDS disease-related knowledge, attitudes, beliefs, and behaviors. Finally, DSTD manages a cooperative agreement with the United States Conference of Mayors. Nineteen cities have received AIDS program grants under this program. The Division is also significantly involved in AIDS training programs. In February, 1985, they conducted 44 one-day seminars on HTLV-III/LAV antibody testing in 34 cities attended by an estimated 7,500 health professionals. In May, 1985, DSTD staff provided training on counseling individuals at alternate test sites in courses that ultimately reached about 1,100 State and local health department staff. In April, 1986, key personnel from nearly every State will be trained to teach a course to their own staff on counseling and sex/needle-sharing partner referral for persons tested for HTLV-III/LAV antibody. Also during April, AIDS program managers from almost every State will attend one of several workshops on AIDS community collaboration and an intensive course on AIDS HE/RR program planning, development, and evaluation. In addition to managing cooperative agreements and providing training, the Division will continue to provide technical assistance and guidance to the States regarding their AIDS HE/RR program activities. Recently, they figured prominently in the development of additional recommendations to reduce sexual and drug abuse-related transmission of HTLV-III/LAV (MMWR, March 14, 1986).

STD program personnel in the States have a diverse and somewhat different configuration of responsibilities related to AIDS. A few States have placed responsibility for AIDS control directly under the STD program. In other areas, STD program staff have generally assisted AIDS program management by providing assistance in establishing and operating alternate testing sites and in providing information to the general public and risk reduction education to groups at high risk. In view of recent CDC recommendations to expand HTLV-III/LAV antibody testing to STD clinics (MMWR, March 14, 1986), it is likely that STD program personnel will assume additional responsibilities particularly in the areas of counseling and sex/needle-sharing partner referral.

RISE IN GONORRHEA CASES

Mr. Conte. Is it true that part of the rise in gonorrhea cases is a result of shifting priorities from STD to AIDS? What other sexually transmitted disease rates are affected the same way?

Dr. Mason. It is unlikely that gonorrhea or other STD rates were affected substantially in Fiscal Year 1985 by a redirection of personnel resources to AIDS. For most of FY 1985, STD resources devoted to AIDS were at the national and State STD management level. It was not until very late in the fiscal year that Federal disease intervention personnel assigned to State and local health departments became involved in AIDS to a significant degree.

The increase in reported gonorrhea in Fiscal Year 1985 can be attributed to a combination of factors. The two most important were: increases in the proportion of all gonorrhea which is resistant to recommended therapy; and changes in the surveillance and reporting systems for gonorrhea in several large project areas.

GRAMM-RUDMAN AND STD PROGRAM

Mr. Conte. The STD program will be affected by the Gramm-Rudman cuts in addition to the diversion of funds for AIDS. Are you comfortable making these kinds of trade offs with the health of people served by this program?

Dr. Mason. We should never be comfortable when the public's health suffers, but CDC is frequently faced with difficult decisions about which of many health priorities to focus upon. While the combination of Gramm-Rudman cuts and diversion of funds for AIDS is not an ideal situation, we can still have effective STD programs by concentrating our efforts on high-yield activities. For example, most of the Gramm-Rudman cuts were to be utilized for the expansion of a nationwide chlamydia prevention and control effort. Our emphasis now must be placed upon implementing those portions of that effort which are less costly, yet most effective. As indicated earlier, the diversion of funds for AIDS also has short- and long-term benefits for STD control, since AIDS health education/risk reduction messages appear to have direct impact on STD morbidity in selected high-risk groups.

FUTURE OF CHLAMYDIAL CONTROL

Mr. Conte. Doctor, I'm confused by two statements in the budget documents. In the justifications you state that the request will "continue to increase support, begun in FY 1984, for development of chlamydial control strategies." However, in the statement on the effects of Gramm-Rudman it says that "special demonstration projects aimed at developing cost-effective control of chlamydia will be reduced and funding for testing, surveillance, and intervention will be discontinued." Which of these statements reflects the future of this control program?

Dr. Mason. The CDC has continued to expand its activities related to chlamydia prevention and control. Grant dollars expended in FY 1985 were more than double that of FY 1984 ($4.4 vs $2.1 million). In FY 1986 and FY 1987 approximately $4.5 million and $4.6 million respectively in grant funds will be devoted to chlamydia control. Control strategies with the most cost benefit to be emphasized within the limit of available resources include: (1) the use of erythromycin for eye prophylaxis in newborns to prevent both gonococcal and chlamydial ophthalmia neonatorum; (2) screening of high-risk pregnant women for chlamydial infection and treating cases and their sexual partners early in pregnancy; (3) selective screening of high-risk, nonpregnant women, particularly those who would not be receiving antichlamydial therapy in STD clinics and other facilities which care for sexually active people; (4) counseling and sex partner referral to assure the medical examination of sex partners as soon as possible; (5) completion of special 318(b) demonstration projects to identify the most efficient ways to improve diagnoses, simplify treatment, and to efficiently bring those groups which transmit a large proportion of chlamydial infections to examination; (6) incorporation of information on the recognition and management of clinical syndromes commonly caused by *Chlamydia trachomatis* into all appropriate programs of medical education and training; (7) treatment of chlamydial infections which frequently coexist with gonococcal infections by employing a gonorrhea treatment regimen effective against both organisms; and (8) treatment on the basis of clinical syndrome alone of women who have purulent cervicitis, urethritis, or salpingitis and men who have urethritis or epididymitis with antibiotics effective against both N. gonorrhoeae and C. trachomatis.

NUMBER OF CHLAMYDIAL INFECTIONS

Mr. Conte. How many people in the U.S. are infected with this disease, and isn't it particularly acute among teenagers and college students?

Dr. Mason. Recent data indicate that an estimated 4 million chlamydia infections occur annually in the United States. As such it is the most common sexually transmitted bacterial pathogen in the United States today. Chlamydia rates are 2-3 fold higher among adolescents than for any other age group.

AGENT ORANGE STUDY

Mr. Conte. Last week the Veterans Administration testified before another of our subcommittees, on which my friend Lou Stokes and I serve, requesting $3.5 million for the Agent Orange Epidemiology Study in FY 1987, an increase of $1.2 million over last year. Through this year, over $60 million has been appropriated to the VA for transfer to CDC to work on this study. How many years have you been working on this, Doctor?

Dr. Mason. CDC started work developing a protocol outlined for this project in FY 1982 while actual funding from the VA began in FY 1983.

Mr. Conte. How much of the money transferred to you by the VA has actually been obligated?

Dr. Mason. Through the end of the first quarter FY 1986 (12/31/85), $56,898,653 have been obligated for CDC's Epidemiologic Studies of the health of Vietnam veterans.

Mr. Conte. What do you estimate the total cost of the study to be, and when is your estimated completion date?

Dr. Mason. The estimated total cost of these studies is approximately $74 million and the current scheduled completion is September 1989. Both the total cost and projected completion date could change depending on the length of the current work stoppage on the Agent Orange exposure component, and the potential negotiated settlement costs with the contractors as a result of the work stoppage.

Mr. Conte. As I understand it, the legislative committees have asked that no major new phase of the study be undertaken until the new methodology or "protocol" is approved by the Office of Technology Assessment. What is the status of this, and when do you expect to resume your work?

Dr. Mason. Protocol development activities are ongoing by the U.S. Army and Joint Services Environmental Support Group, the Agent Orange Working Group Science Panel, and CDC. Completion of this work is anticipated by May or June 1986. Until the revised protocol is reviewed and approved by OTA, the date upon which we can resume work cannot be determined.

HOSPITAL ASSOCIATED INFECTIONS

Mr. Conte. Doctor, last week one of the NIH Directors testified that close to 10 percent of patients admitted to hospitals in this country get infected while in the hospital. Your justifications put that figure closer to 5 percent. Either way, that's way too much. What activity does CDC support to prevent these hospital associated infections from occurring?

Dr. Mason. CDC develops and disseminates guidelines for the prevention and control of hospital-acquired infections (e.g. pneumonia, urinary tract, surgical wound, and intravascular infections). CDC investigates outbreaks of hospital-acquired infections and recommends specific prevention and control measures to hospitals. CDC also conducts prospective studies to evaluate prevention and control activities and strategies for nosocomial infections.

Mr. Conte. Doctor, you know, I think this is a better way to reduce Medicare and Medicaid expenditures than some of the proposals I've seen in the budget the past few years. You let us know how much money you need for this. Tell me, how much will you spend on these activities in FY 1987, and how low do you think you can bring the number of these infections.

Dr. Mason. CDC expects to spend $3.2 million on activities directed at prevention and control of nosocomial infections. In 1983 there was a reduction of 9% in the incidence of nosocomial infections in acute-care hospitals. By 1987 we expect the reduction of nosocomial infections to be 14% of what otherwise would pertain in the absence of hospital control programs.

ERC FUNDING

Mr. Conte. Your budget again proposes to eliminate funding for the Educational Resource Centers under the National Institute for Occupational Safety and Health. You know, I get a lot of letters on this every year. What evidence do you have that states and industry will pick up the slack if we agree to your proposal?

Dr. Mason. It is the Administration's belief that continued support for the ERCs should come from those non-Federal sources who benefit directly from the employment of those occupational safety and health professionals who received academic or continuing education training from the ERCs.

The ERCs currently receive approximately 25 percent of their funding from sources other than the federal training grant. Two California ERCs have supplementary State funding. The Washington ERC receives some funding from the Statewide workers compensation funding pool. Some of the State-funded universities with ERCs have increased faculty support. The ERCs have begun discussions with potential non-Federal funding groups. The American Industrial Hygiene Foundation has developed a trust fund to provide some scholarships and grants to individual students. These funds include donations from corporations and individual donations from AIHA members. More recently, the American Occupational Medical Association is exploring the feasibility of private funding sources for occupational-medical residency programs. The universities will have to explore expansion of these alternate funding sources in order to support the ERC programs.

NIOSH RECOMMENDATIONS TO DEPARTMENT OF LABOR

Mr. Conte. Your justifications state that since 1972, NIOSH has recommended 123 standards to the Department of Labor to help protect workers from particular hazards. Do you have any figures on how many of these were adopted by the Department and are now in use?

Dr. Mason. Of the 118 criteria documents transmitted to the Department of Labor (DOL), the DOL has exactly incorporated the recommendations from seven of these criteria documents into standards. However, generally, NIOSH recommendations for standards, which reflect the findings of research, are not exactly incorporated into standards being promulgated by the DOL. NIOSH recommendations are only one portion of the information the DOL considers in deciding to promulgate a standard. The DOL also considers the economic factors related to possible regulatory actions and considers public policy issues in determining whether to promulgate regulations and in determining the nature of those regulations.

RAPE PREVENTION AND SERVICES

Mr. Conte. Doctor, another issue I've been getting some mail on recently has to do with the funding for State rape prevention services under the block grant. Will these services be affected by the Gramm-Rudman cuts?

Dr. Mason. Rape prevention and services to rape victims will not be affected by the Gramm-Rudman Act. The Preventive Health and Health Services Block legislation requires $3.5 million be set aside for rape activities regardless of the total amount available for the block grants.

Mr. Conte. By law aren't you required to provide $3.5 million for these services out of the block grant monies, so these services would not be affected in FY 1987?

Dr. Mason. Yes, that is absolutely correct.

USER FEES FOR PROFICIENCY TESTING

Mr. Conte. Doctor, last year we allowed you to begin collecting user fees from proficiency testing. How much do you estimate will be collected in FY 1986?

Dr. Mason. We are now in the process of announcing these user fees in the Federal Register. Since we are late implementing these fees, we would anticipate collecting over $300,000 in FY 1986.

Mr. Conte. Are you getting many complaints about having to charge for these savings?

Dr. Mason. Since we are only now announcing the proposal to collect, it is to early for us to receive any complaints.

VIROLOGY LAB CONSTRUCTION

Mr. Conte. What is the state of construction on your new virology lab down in Atlanta?

Dr. Mason. The lab construction is now 16% complete and on schedule.

REYE'S SYNDROME

Mr. Young. Dr. Mason, I have been concerned for many years about Reye Syndrome and the continuing mystery which surrounds this life threatening children's disease. I was encouraged to learn earlier this year that even though we are in the midst of the flu season, when the risk of Reye Syndrome is highest, that the CDC reported a drop off in the number of reported cases. What do your figures show for this year compared to past years and to what do you attribute this fall in Reye Syndrome cases?

Dr. Mason. Mr. Young, the following figures are provided:

Year	Reye Syndrome Cases
1980	555
1981	297
1982	213
1983	198
1984	204
1985*	91

*Data for 1985 are preliminary and based on case reports as of January 15, 1986.

The low reported Reye syndrome incidence in 1985 occurred during widespread publicity about the probable increased risk of Reye syndrome associated with the use of aspirin for teenagers, as well as for younger children, with influenza-like illnesses or chicken pox.

DIABETES CONTROL PROJECTS

Mr. Young. A second public health concern of mine is diabetes. The problems associated with diabetes are particularly acute in Florida with our large aging population. It's my understanding that Pinellas County, Florida, which I represent and has an estimated 72,000 diabetics, is next in line to receive a $150,000 CDC diabetes control project grant to improve the county's ability to care for diabetics and to educate diabetics and their families about the disease. I note, however, that your budget request includes a rescission request for the $5 million diabetes control program in 1986 and no funding request for the program in 1987. Can you provide me with more information about your request for this program?

Dr. Mason. Over the past 5-8 years, 20 States have been federally funded to carry out diabetes demonstration projects. The goal of these programs has been to reduce complications of diabetes by developing patient and provider education programs and improving the health care delivery system. A secondary goal of the program has been to achieve self-sufficiency. Many of these projects have been shown to be cost-effective and have developed comprehensive State plans for diabetes control and/or have ongoing community based projects. Because of the need to constrain Federal spending, we believe it is now appropriate for these demonstration projects to be continued by the States or other third-party payors who have also benefitted financially from their success.

In 1984, four to five States made in-kind contributions of approximately $3.5 million while 15 other States have contributed a total of $1 million. In several States, third-party payers now cover the cost of certain services such as patient education. This number is expected to increase. In addition, other non-project States, such as Texas, Maryland, Iowa, and North Dakota, have either started their own diabetes control programs or secured third-party reimbursement for patient education without Federal financial support.

CDC will continue to provide technical assistance, develop consensus, and actively disseminate information on effective control and evaluation strategies. We will also continue to encourage States to establish linkages with organizations providing funds for service delivery in order to capitalize on existing resources, and will encourage use of block grant funding for diabetes control efforts.

Mr. Porter. I am interested in the current status of funding for State Diabetes Control Projects. The Illinois Department of Public Health, for example, has operated a Diabetes Control Program for eight years with considerable success. What is the current situation with regard to funding of these projects?

Dr. Mason. The State Diabetes Control projects were developed as a 5 year demonstration project. These demonstrations have yielded considerable information on intervention methodology. The demonstration phase is now ending, and it is hoped that the States, which have benefited so much from these projects, will now continue and expand them with State or private funds. The funds provided by Congress in 1986 are proposed for rescission and no funds are requested in 1987.

Mr. Porter. What effect would your budget request and the recent sequestration have on these programs?

Dr. Mason. These programs should obtain funds from alternative sources to continue.

This program was designed as a 5-year demonstration program. During its 5 years, the program has proven successful in developing methodology to reduce complications of diabetes and in developing State self-sufficiency. The budget request would eliminate Federal funding for these programs. A goal of this 5-year demonstration has been to develop State self-sufficiency in diabetes control. Four to five States made in-kind contributions of approximately $3.5 million to support the State diabetes control programs, while 15 other States contributed a total of $1 million. Other States have been successful in obtaining third-party reimbursement for diabetes patient education programs.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR DISEASE CONTROL

Disease Control, Research, and Training

FY 1987 Budget

Page

Appropriation language 2

Appropriation language analysis 3

Amounts available for obligation 5

Summary of changes 6

Budget authority by activity 7

Budget authority by object 9

Significant items in House and Senate Appropriations Committee Reports 11

Authorizing legislation 18

Appropriation History Table 20

Justification:
  Narrative:
    A. General Statement 21
    B. Program Accomplishments 21
    C. Preventive Health & Health Services Block Grants. 24
    D. Prevention Centers 26
    E. Sexually Transmitted Diseases 27
    F. Immunization 31
    G. Infectious Diseases 35
    H. Chronic and Environmental Disease Prevention 42
    I. Occupational Safety and Health 50
    J. Epidemic Services 61
    K. Buildings and Facilities 67
    L. Program Management 69
    M. State Tables 71
    N. Estimates for Consulting Services 73
    O. Estimates for Related Services 75
    P. Detail of Permanent Positions 77

CENTERS FOR DISEASE CONTROL

Disease Control, Research, and Training

To carry out titles III and XIX and sections 1102 of the Public Health Service Act, Sections 101, 102, 103, 201, 202, and 203 of the Federal Mine Safety and Health Act of 1977, and sections 20, 21, and 22 of the Occupational Safety and Health Act of 1970; including insurance of official motor vehicles in foreign countries; and hire, maintenance, and operation of aircraft, [$471,861,000] *$379,846,000*, of which [$3,797,000] *$1,810,000* shall remain available until expended for equipment and construction and renovation of facilities[, and of which $6,900,000 shall remain available until September 30, 1987 for the purchase and distribution of drugs, and of which $2,000 shall be used to establish, maintain, and operate a twenty-four-hour telephone hotline which permits calls to be made without charge to the caller, which provides general information concerning acquired immune deficiency syndrome and information concerning medical services and housing facilities for individuals with such syndrome, and which refers such individuals to counseling services]: *Provided*, That training of employees of private agencies shall be made subject to reimbursement or advances to this appropriation for the full cost of such training: *Provided further*, That [not to exceed $1,266,000 in] collections from user fees, including collections from training and reimbursements and advances for the full cost of proficiency testing of private clinical laboratories, may be credited to this appropriation[: *Provided further*, That $10,000,000 shall be derived from unobligated balances provided under Public Law 94-266 for national influenza immunization: *Provided further*, That $1,000,000 shall be used for studies of designer or synthetic drug use].

(Department of Health and Human Services Appropriation Act, 1986)

Preventive Health Services

Language Analysis

Language Provision	Explanation
"...including insurance of official motor vehicles in foreign countries...".	No specific authorization exists for the provision regarding insurance; however, experience of the Centers for Disease Control in stationing Public Health Service officials overseas and at the Mexican Border indicates that this provision is essential. Unless adequate automobile insurance is provided, Public Health Service officials could be subject to arbitrary arrest if they were involved in an accident.
"...and hire, maintenance, and operation of aircraft...".	The Centers for Disease Control must maintain the ability to hire aircraft for testing of new insecticides and formulations and for applying the insecticides when outbreaks of mosquito-borne disease, such as encephalitis, occur in populous areas where no other method can be used to control the spread of the disease. Authority to purchase aircraft is no longer necessary and has been deleted.
"...of which $1,810,000 shall remain available until expended and shall be for construction and renovation of facilities..."	Repair and construction projects, require lead time for planning, designing, and contracting procedures, which require longer than the fiscal year to complete and obligate, funds.
"...that training of employees of private agencies shall be made subject to reimbursement or advances to this appropriation for the full cost of such training..."	Provides specific authorization for depositing funds to this appropriation which are collected for training of health workers from private agencies, to offset the cost of the training provided.

Language Provision	Explanation
"...that collections from user fees, including collections from training and reimbursements and advances for the full cost of proficiency testing of private clinical laboratories, may be credited to this appropriation."	Provides specific authorization to allow charging for the full cost of proficiency testing of private clinical laboratories and to allow all funds collected as user fees to be deposited to this appropriation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DISEASE CONTROL, RESEARCH, AND TRAINING
CENTERS FOR DISEASE CONTROL
Amounts Available for Obligation /1

	1985	1986	1987
Appropriation:			
Annual.............................	$410,530,000	$471,861,000 /2	$379,846,000
Sequester order....................	---	-20,290,000	---
Proposed rescission...............	---	-34,096,000	---
Subtotal, adjusted appropriation..	410,530,000	417,475,000	379,846,000
Comparative transfer to:			
Public Health Service Management for:			
AIDS.............................	-28,231,000	-50,285,000	---
Subtotal, adjusted budget authority.	382,299,000	367,190,000	379,846,000
Receipts and reimbursements from:			
Non-federal sources:			
User fees........................		447,000	466,000
Unobligated balance, start of year.....................	20,139,000	25,840,000 /2	
Recovery of prior year obligations..	10,000,000		
Unobligated balance, end of year......................	-35,840,000	---	
Unobligated balance lapsing.........	58,000	-471,000 /3	
Total obligations...............	376,656,000	393,006,000	380,312,000

/1 Excludes the following amounts for reimbursable activities carried out by this account: 1985 - $61,505,000; 1986 - $30,000,000; 1987 - $75,800,000.

/2 Appropriation provided by Congress specified that $10,000,000 was to be derived from unobligated balance of Swine Flu Immunization carried forward from prior year.

/3 Reduction required by section 513 of the Treasury-Postal Services Appropriation Act of 1986.

SUMMARY OF CHANGES

1986 Estimate	$471,861,000
1986 Sequester order	-20,290,000
1986 Proposed rescission	-34,096,000
1986 Comparative transfer	-50,285,000
Total estimated budget authority	367,190,000
(Obligations)	(393,006,000)
1987 Request	379,846,000
(Obligations)	(380,312,000)
Net change	+12,656,000
(Obligations)	(-12,694,000)

	1986 base	Change from base
Increases:		
Built-in:		
1. Within grade increases to FICA	$99,553,000	+$2,431,000
2. Office of Federal Employees Compensation	556,000	+56,000
3. Utilities, fuel, & GSA car rental	4,966,000	+209,000
4. SLUC	1,443,000	+72,000
5. FTS and telecommunications	5,002,000	+210,000
6. Computer center increase	9,258,000	+523,000
7. Laboratory supplies & scientific equipment	15,615,000	+657,000
8. PHS service and supply fund	1,377,000	+53,000
9. Cost of living increase:		
Preventive health block grants	87,549,000	+1,966,000
Sexually transmitted diseases	53,865,000	+1,375,000
Immunization	56,895,000	+2,650,000
Infectious diseases	35,159,000	+275,000
Chronic and environmental disease prevention	23,323,000	+480,000
Occupational safety and health	56,168,000	+2,545,000
Epidemic services	49,093,000	+1,128,000
Buildings and facilities	27,527,000	+78,000
Program management	2,959,000	+26,000
Program:		
Epidemic services- Infant mortality	---	+1,750,000
Subtotal		+16,484,000
Decreases:		
Program:		
Immunization- Vaccine stockpile	3,838,000	-3,828,000
Subtotal		-3,828,000
Net change		+12,656,000

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL
Disease Control, Research, and Training

Budget Authority by Activity

	1986 Appropriation	1986 Available after Sequestering	1986 Revised	1987
Preventive Health & Health Services Block Grants:				
Grants......................	90,958,000	87,047,000	87,047,000	89,000,000
Program operations..........	525,000	502,000	502,000	525,000
Subtotal.................	91,483,000	87,549,000	87,549,000	89,525,000
Prevention Centers............	1,500,000	1,436,000 /1	- /1 /2	-
Sexually Transmitted Diseases:				
Grants......................	46,511,000	44,511,000	44,511,000	45,510,000
Program operations..........	9,774,000	9,354,000	9,354,000	9,943,000
Subtotal.................	56,285,000	53,865,000	53,865,000	55,453,000
Immunization:				
Grants......................	47,359,000	45,323,000	45,323,000	47,666,000
Program operations..........	8,235,000	7,744,000	7,744,000	8,346,000
Vaccine stockpile...........	4,000,000	3,828,000 /1	3,828,000 /1 /3	-
Subtotal.................	59,594,000	56,895,000	56,895,000	56,012,000
Infectious Diseases...........	106,698,000	39,944,000 /1	35,159,000 /1 /2	36,358,000
(AIDS)......................	(64,925,000)/6	(62,133,000)/6	(50,285,000)/6 /2	(45,800,000)/6
Chronic and Environmental Disease Prevention...........	30,425,000	29,065,000 /1	23,323,000 /1 /2	24,425,000
Occupational Safety and Health:				
Research....................	58,923,000	56,168,000 /1	56,168,000 /1	60,036,000
Training....................	8,760,000	8,383,000 /1	- /1 /2	-
Subtotal.................	67,683,000	64,551,000	56,168,000	60,036,000
Epidemic Services.............	51,766,000 /7	49,561,000 /1/7	49,561,000 /1 /4/7	53,597,000/7
Buildings & Facilities........	3,797,000	29,429,000	27,527,000 /2 /5	1,810,000
Program Management............	3,096,000	2,959,000 /1	2,959,000 /1	3,096,000
Total obligations...........	472,327,000	415,254,000	393,006,000	380,312,000

	1986 Appropriation	1986 Available after Sequestering	1986 Revised	1987
Offsetting collections........	-466,000 /7	-447,000 /7	-447,000 /7	-466,000 /7
Unobligated balance, start of year...............		-25,840,000	-25,840,000	---
Unobligated balance, end of year.................	---	---	---	---
Unobligated balance, lapsing.....................		+471,000 /1	+471,000 /1	---
Total budget authority......	471,861,000	389,438,000	367,190,000	379,846,000

/1 Reflects obligations withheld totaling $471,000 for the appropriation, as required by Section 515 of the Treasury-Postal Service Appropriation Act, 1986.

/2 Reflects portion of rescission totaling $34,096,000 for the appropriation.

/3 Includes $5,000 in unobligated balance carried forward from prior year.

/4 Includes $40,000 in unobligated balance carried forward from prior year.

/5 Includes $25,795,000 in unobligated balance carried forward from prior year.

/6 Funding for AIDS in 1987 in the amount of $45,800,000 is requested under the appropriation "Priority Disease Control and Research", Office of the Assistant Secretary for Health. The 1986 amounts shown here as non-add items have been excluded from 1985 and 1986 (except 1986 appropriation) to provide comparability to 1987.

/7 Includes User Fee collections in Epidemic Services, reflecting an offset to budget authority.

Budget Authority by Object

	1985 Actual	1986 Current Estimate	1987 Estimate
Total number of full-time permanent positions	3,784	3,582	3,582
Full-time equivalent of all other positions	220	220	220
Total compensable workyears	3,938	3,712	3,712
Average ES salary	$67,399	$67,399	$67,399
Average GS Grade	9.766	9.830	9.830
Average GS salary	$30,383	$30,805	$30,805
Average grade, grades established by Act of July 1, 1944 (42 U.S.C. 207):	4.62	4.63	4.63
Average salary, grades established by Act of July 1, 1944 (42 U.S.C. 207):	$36,467	$37,560	$37,560
Average salary of ungraded positions.	$22,679	$23,307	$23,307

Personnel compensation:			
Permanent positions	$91,218,000	$92,502,000	$94,182,000
Positions other than permanent	6,686,000	7,051,000	7,051,000
Other personnel compensation	4,078,000	3,921,000	3,921,000
Subtotal, personnel compensation.	101,982,000	103,474,000	105,154,000
Personnel benefits	19,390,000	20,843,000	21,650,000
Travel and transportation of persons.	5,763,000	5,535,000	5,535,000
Transportation of things	1,095,000	1,393,000	1,393,000
Rent, communications and utilities ..	9,899,000	10,441,000	10,708,000
Standard level user charges	1,440,000	1,443,000	1,515,000
Printing and reproduction	1,184,000	1,128,000	1,128,000

	1985 Actual	1986 Current Estimate	1987 Estimate
Other services	15,684,000	15,283,000	15,934,000
Project contracts	4,458,000	8,210,000	15,535,000
Supplies and materials	24,491,000	24,271,000	20,688,000
Equipment	10,191,000	10,708,000	11,123,000
Lands and structures	500,000	26,368,000	671,000
Grants, subsidies and contributions	180,551,000	163,909,000	169,278,000
Insurance claims and indemnities	28,000	-	-
Total obligations by object	376,656,000	393,006,000	380,312,000
Offsetting collections	---	-447,000	-466,000
Recovery of prior year obligations	-10,000,000	-25,840,000	---
Unobligated balance, start of year	-20,139,000	---	---
Unobligated balance, end of year	+35,840,000	---	---
Unobligated balance, lapsing	-58,000	+471,000	---
Total budget authority by object	382,299,000	367,190,000/1	379,846,000

/1 Reflects a reduction of $20,290,000 for the Gramm-Rudman activity and $34,096,000 for a proposed rescission.

Significant Items in House and Senate Appropriation Committee Reports

Item	Action Taken or to be Taken
1986 House Report #99-289	
Chlamydia Infections	
1. The Committee continues to be concerned about the increase of chlamydia infections and the effect that these infections have on unborn children. Consequently, the Committee was pleased to note the recent publication by CDC of policy guidelines for prevention and control of these infections. The Committee urges CDC to continue to place strong emphasis on this problem.	1. The CDC has continued to expand its activities related to chlamydia prevention and control. Grant dollars expended for chlamydia control in FY 1985 were more than double that of FY 1984 ($4.8 vs. $2.1 million). Seventeen STD project areas now have comprehensive chlamydia control programs. The CDC will expand its nationwide chlamydia control effort to include research, surveillance, diagnosis, treatment, and counseling by establishing firm annual incidence figures, continuing cost effectiveness studies, completing special 318(b) demonstration projects, continuing diagnostic, surveillance and epidemiologic research studies, and expanding the more effective "syndromic" approach to chlamydia control nationwide. Numerous studies have identified several clinical syndromes associated with chlamydia. In the absence of an inexpensive, simple, and reliable laboratory test for chlamydia, the initiation of treatment based on the presence of several of these clinical syndromes provides the most effective control.
Acquired Immunodeficiency Syndrome (AIDS)	
2. The Committee directs CDC, together with the Division of MCHS, to provide significantly increased funding for urgently needed AIDS risk reduction, education and	2. The CDC is aware that the National Hemophilia Foundation has developed a comprehensive plan to provide AIDS risk reduction education for

1986 House Report #99-289

Acquired Immunodeficiency Syndrome (AIDS) (Cont'd)

Item	Action Taken or to be Taken
training in the hemophilia community. The Committee expects that such a program would support the development of regionally-based social support/family stress teams and training of physicians, other health care personnel and self-help support groups in AIDS/HTLV-III risk reduction. All aspects of this program should involve the hemophilia treatment centers and their subregional facilities.	hemophiliacs and the significant others in their lives. While specific details of this plan have not been communicated to CDC, we support the concept and intend to support the Foundation in implementing this activity. In addition, CDC will work through official health agencies receiving AIDS-related cooperative agreement support to include establishing collaborative relationships with each local Hemophilia Treatment Center.
3. The Committee understands that nearly $21,000,000 will be available to develop and implement AIDS health education/risk reduction programs. The Committee believes it is important that as an integral part of the risk reduction effort CDC carries out a national AIDS education program and strategy. Included in such a program should be the following elements: (a) a public information campaign using the most appropriate channels of communication to reach those at highest risk of AIDS/HTLV-III infection; (b) technical assistance, training, and other such assistance designed to diffuse effective risk reduction strategies to State/local health agencies and AIDS health care organizations; and (c) a coordinated program to develop and evaluate model community risk reduction approaches. In developing and implementing this national program, CDC shall seek the assistance of outside experts in AIDS community risk reduction/health education.	3. On January 27, 1986, CDC published an announcement in the Federal Register of the availability of funds for programs of AIDS health education and risk reduction. Programs funded under that announcement will involve efforts to reach those at highest risk of AIDS/HTLV-III infection with information to reduce their capacity for spreading the virus; technical assistance to support State/local efforts to carry out these initiatives; and demonstration programs to evaluate the most effective known approaches to AIDS risk reduction. Before publishing this announcement, CDC convened 14 professionals representing a wide variety of groups and organizations from the public and private sectors with interest and experience in AIDS to assess each aspect of the draft announcement. CDC made the commitment to reconvene this or a similar group of outside experts at future points as program experience accumulates and/or technological developments indicate the need.

Item	Action Taken or to be Taken
1986 House Report #99-289	
Acquired Immunodeficiency Syndrome (AIDS) (Cont'd)	
	Evaluation of proposals submitted in response to the announcement will be based on criteria which include evidence that the applicant will maintain close collaboration with community based organizations serving the interests of groups at risk for AIDS.
Hepatitis B/Liver Cancer	
4. The Committee recommends that CDC take steps to strengthen the hepatitis B/liver cancer prevention activities in community settings, with special emphasis on prevention of mother-to-child transmission in high-risk groups. Such activities should include community outreach and patient care follow-up strategies.	4. A Memorandum of Understanding has been signed between the CDC, Department of the Interior, and the American Samoa Government establishing a hepatitis B vaccine project with the goal of vaccinating all susceptible American Samoans within a 3 year period. Objectives for FY 1986 include complete screening and vaccination of susceptible persons in half of the American Samoa villages, screening all pregnant women, treating infants of carrier mothers with hepatitis B immune globulin plus hepatitis B vaccine, and establishing a hepatitis B virus carrier registry. In FY 1987, CDC plans to assess the screening methodology for predicting hepatitis B positivity among prenatal women in hospitals in Chicago and Atlanta to better define parameters for preventing perinatal (mother-to-child) hepatitis B virus transmission.
Center for Injury Control	
5. The Public Health Service is directed to cooperate with the Department of Transportation's National Highway	5. Efforts are underway to create a reimbursable agreement between the Centers for Disease Control (CDC)

Item	Action Taken or to be Taken
1986 House Report #99-289	
Center for Injury Control (Cont'd)	
Traffic Safety Administration to establish a center for injury control within the Centers for Disease Control as recommended by the National Academy of Science's Committee on Trauma Research in its report Injury in America: A Continuing Public Health Problem. The funding for the Center for FY 1986 will be provided by the Department of Transportation. The Public Health Service shall make at least twenty full-time permanent positions available for the management and operation of the Center.	and the Department of Transportation (DOT) whereby DOT will fund injury control activities within CDC as recommended by the committee. Twenty full-time permanent positions have been provided for the management and operation of the Center as directed by the Committee.
1986 Senate Report #99-151	
Prevention Centers	
1. The Department should consider the establishment of an international center focusing on collaborative efforts in the Pacific Basin and Southeast Asia.	1. The rescission proposed for FY 1986 includes the funds for Prevention Centers of which the Committee directed consideration be given to the establishment of an international center.
Sexually Transmitted Diseases	
2. The Committee continues to be concerned about the incidence of other sexually transmitted diseases such as chlamydia. The Committee therefore recommends that CDC consider establishing a national system for surveillance and control of this serious health problem.	2. In January 1984, the CDC implemented a surveillance system for collecting and monitoring reported cases of chlamydial infection for males and females by each State. This system will require state reporting laws and/or regulations to provide the necessary support for prevention activities. Reporting laws promote and legitimize the involvement of public health authorities in assuring adequate individual patient management - including referral of sex partners - and may facilitate

Item	Action Taken or to be Taken
1986 Senate Report #99-151 Sexually Transmitted Diseases (Cont'd)	other activities such as screening and education. Moreover, case reporting provides a uniform basis for describing the extent and trend of disease. As States implement reporting laws and regulations (expected to be completed by 1990) and achieve uniform definitions, the national surveillance system will provide a useful supplement to data currently available. CDC is expanding the weekly gathering, collating, and analyzing of morbidity data. In addition, CDC will expand its chlamydia control effort to include research, diagnosis, treatment, and counseling by continuing cost effectiveness studies, completing special 318(b) demonstration projects, continuing diagnostic and epidemiologic research studies, and expanding the more effective "syndromic" approach to chlamydia control nationwide. Numerous studies have identified several clinical syndromes associated with chlamydia. In the absence of an inexpensive, simple, and reliable laboratory test for chlamydia, the initiation of treatment based on the presence of several of these clinical syndromes provides the most effective control.
Acquired Immunodeficiency Syndrome (AIDS) 3. The Committee directs CDC to work with the hemophilia community to provide education and training for the prevention of AIDS and hemophilia complications.	3. The CDC is aware that the National Hemophilia Foundation has developed a comprehensive plan to provide AIDS risk reduction education for hemophiliacs and

Item	Action Taken or to be Taken
1986 Senate Report #99-151 Acquired Immunodeficiency Syndrome (AIDS) (Cont'd)	
	the significant others in their lives. While specific details of this plan have not been communicated to CDC, CDC supports the concept and intends to support the Foundation in implementing this activity. In addition, CDC will work through official health agencies receiving AIDS-related cooperative agreement support to include establishing collaborative relationships with each local Hemophilia Treatment Center.
4. The Committee expects that CDC's health education/risk factor reduction programs regarding AIDS have a national focus and include the following: (a) A public information campaign using the most appropriate channels of communication to reach those at highest risk of AIDS/HTLV-III infections; (b) technical assistance, training, and other assistance designed to disseminate effective risk reduction strategies to State/local health care organizations; and (c) a coordinated program to develop model community risk reduction approaches and evaluation mechanisms to monitor their effectiveness. The Committee directs CDC in developing and implementing this national program, to seek the assistance of and work in collaboration with outside experts in AIDS community risk reduction/health education efforts.	4. On January 27, 1986, CDC published an announcement in the Federal Register of the availability of funds for programs of AIDS health education and risk reduction. Programs funded under that announcement will involve efforts to reach those at highest risk of AIDS/HTLV-III infection with information to reduce their capacity for spreading the virus; technical assistance to support State/local efforts to carry out these initiatives; and demonstration programs to evaluate the most effective known approaches to AIDS risk reduction. Before publishing this announcement, CDC convened 14 professionals representing a wide variety of groups and organizations from the public and private sectors with interest and experience in AIDS to assess each aspect of the draft announcement. CDC made the commitment to reconvene this or a similar group of outside experts at future points as program experience accumulates and/or technological developments indicate the need.

Item	Action Taken or to be Taken
1986 Senate Report #99-151	
Acquired Immunodeficiency Syndrome (AIDS) (Cont'd)	
	Evaluation of proposals submitted in response to the announcement will be based on criteria which include evidence that the applicant will maintain close collaboration with community based organizations serving the interests of groups at risk for AIDS.
Long-Range Facility Plan	
5. To provide the Committee with a better understanding of CDC's facilities requirements, the Committee requests that a copy of the Centers for Disease Control's long-range facility plan be forwarded to the Committee as soon as this material becomes available.	5. A copy of the plan will be submitted to the committee prior to the FY 1987 budget hearings.

Authorizing Legislation

Preventive Health Services Activity:	1986 Amount Authorized	1986 Revised Estimate	1987 Amount Authorized	1987 Budget Request
1. Preventive health and health services block grant:				
Grants: PHSA Section 1901(a)	$98,500,000	$87,047,000	$98,500,000	$89,000,000
Program Operations: PHSA Sections 301, 304, 306, 307, 308, 310, 311, and 327	Indefinite	$502,000	Indefinite	$525,000
2. Sexually transmitted diseases:				
Grants: PHSA Section 318(e)(1)	$62,500,000	$44,511,000	$68,000,000	$45,510,000
Program Operations: PHSA Sections 301, 304, 306, 307, 308, 310, 311, and 327	Indefinite	$9,354,000	Indefinite	$9,943,000
3. Immunization:				
Grants: PHSA Section 317(j)(1)	$59,000,000	$45,323,000	$65,000,000	$47,666,000
Program Operations: PHSA Sections 301, 304, 306, 307, 308, 310, 311, and 327	Indefinite	$11,572,000	Indefinite	$8,346,000
4. Infectious disease prevention: PHSA Sections 301, 304, 306, 307, 308, 310, 311, 327, 352, and 1102	Indefinite	$35,159,000	Indefinite	$36,358,000
5. Chronic and environmental disease prevention: PHSA Sections 301, 304, 306, 307, 308, 310, 311, 327, 352, and 1102	Indefinite	$23,323,000	Indefinite	$24,425,000
6. Occupational Safety and Health: Research: PHSA Sections, 301, 304, 306, 308, 310, 311, 327; the Occupational Safety and Health Act of 1970, Sections 20, 21, and 22; and the Federal Mine Safety and Health Act of 1977, Sections 101, 102, 103, 201, 202 and 203	Indefinite	$56,168,000	Indefinite	$60,036,000

Authorizing Legislation - Continued

	1986 Amount Authorized	1986 Revised Estimate	1987 Amount Authorized	1987 Budget Request
7. Epidemic Services: PHSA Sections 301, 304, 306, 307, 308, 310, 311, 322, 325, 327, 352, 361 thru 369, and 1102	Indefinite	$49,114,000	Indefinite	$53,131,000
8. Buildings and Facilities: PHSA Section 321(a)	Indefinite	$27,527,000	Indefinite	$1,810,000
9. Program Management: Title III, XIX, and Section 1102 of the Public Health Service Act; the Federal Mine Safety and Health Act of 1977, Sections 20, 21, and 22; and the Occupational Safety and Health Act of 1970, Sections 101, 102, 103, 201, 202, and 203	Indefinite	$2,959,000	Indefinite	$3,096,000
Unfunded authorizations:				
1. Tuberculosis Grants: PHSA Section 317(j)(2)	$9,000,000	--	$10,000,000	--
2. Prevention Centers: PHSA Section 1706(e)	$8,000,000	--	$13,000,000	--
3. Prevention Planning Grants: PHSA Section 1910A(b)	$5,000,000	--	$5,000,000	--
Total Appropriation		$392,559,000		$379,846,000
Total Appropriation Against Definite Authorizations	$242,000,000	$176,881,000	$259,500,000	$182,176,000

BEST COPY AVAILABLE

Disease Control, Research, and Training

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
1978	193,162,000	209,426,000	210,255,000	217,741,000
1979	243,910,000	249,310,000	256,539,000	263,972,000
1980	312,835,000	264,915,000	298,415,000	296,125,000
1981	293,441,000	329,441,000	---	286,228,000
1982	179,193,000	231,590,000	212,187,000	231,349,000
1983	217,192,000 /1	321,039,000	329,368,000	337,916,000
1984	270,023,000 /1	373,405,000	369,896,000	374,504,000
1985	280,364,000 /1	198,802,000 /2	402,730,000	410,530,000
1986	392,092,000	441,194,000	480,277,000	471,861,000
1986 Sequester	-20,290,000			
1986 Proposed rescission	-34,096,000			
1987	379,846,000 /3			

/1 Funds for the Preventive Health and Health Services Block Grants were requested in the Grants to States for Health appropriation.

/2 Preventive Health and Health Services Block Grants, Venereal Disease Grants, and Immunization Grants not considered due to pending request for extension of authorization which expired in 1984.

/3 Funding for AIDS in 1987 in the amount of $45,800,000 is requested under the appropriation "Priority Disease Control and Research", Office of the Assistant Secretary for Health.

General Statement

The Centers for Disease Control (CDC) is the focal point within the Public Health Service for prevention application. By setting national objectives, conducting investigations, studies, surveillance, and training, and developing health promotion strategies, CDC seeks to improve the health and quality of life of the people of the United States.

To accomplish this objective, CDC: identifies and defines preventable health problems and maintains active surveillance of diseases through epidemiologic and laboratory investigations and data collection, analysis, and distribution; serves as the PHS lead agency in developing and implementing operational research aimed at developing and testing effective disease prevention, control, and health promotion programs; responds to public health emergencies; operates a national program to address environmentally-related health problems; administers a national program to develop recommended occupational safety and health standards and to conduct research, and technical assistance to assure safe and healthful working conditions for employees; develops and implements a program to sustain a strong national public health workforce; and conducts a national program for improving the performance of clinical laboratories.

CDC is responsible for controlling the introduction and spread of infectious diseases, and provides consultation and assistance to other nations and international agencies to assist in improving their disease prevention and control, environmental health, and health promotion activities. CDC administers the Preventive Health and Health Services Block Grant and specific preventive health categorical grant programs while providing program expertise and assistance in responding to Federal, State, local, and private organizations on matters related to disease prevention and control activities.

Effects of Proposed Legislation

The President's appropriation request of $379,846,000 for this account represents current law requirements. No proposed law amounts are included.

Program Accomplishments

A landmark in medical history was achieved with the eradication of smallpox, one of the most dreaded diseases in the world. CDC's participation in, and contribution to, the campaign against smallpox was a major cause of the campaign's success. The amount contributed by the United States is saved by the citizens of this country every three months because routine smallpox vaccination is no longer required.

While engaged in campaigns against age old public health enemies, CDC's scientists have been working to learn more about Acquired Immunodeficiency Syndrome (AIDS). CDC scientists found the homing mechanism used by the AIDS virus to infect white blood cells improves chances that a vaccine can be developed against the deadly disease. The work involves isolating tiny surface molecules on the virus as well as the matching molecules found on the type of blood cells which the virus attacks.

The AIDS Program evaluated, in cooperation with the Atlanta Red Cross, the sensitivity and specificity of the Abbott serologic test (EIA) to detect antibody to HTLV-III through the testing of 75,000 blood units. The study validated the use of this serologic testing procedure by U.S. blood and plasma collection facilities.

In the AIDS Program study of family members of AIDS patients at Montefiore Medical Center in New York City, a total of 101 household contacts of 39 AIDS patients have been evaluated. Other than the expected transmission between sexual partners and from infected mother to infant child, no evidence of HTLV-III transmission within the household was found. This study provides both strong evidence that "casual" transmission of HTLV-III does not occur and important support for guidelines on the care of AIDS patients and the education of children with AIDS.

Developed a microcomputer software system for the interactive entry, analysis, and transmission to CDC of nosocomial infection surveillance data by National Nosocomial Infections Study (NNIS) hospital infection control personnel and transmission of data to CDC.

Follow-up of participants in the CDC sponsored hepatitis B vaccine trials continued to show excellent protection against infection after 5 years.

Through the Childhood Immunization program record low levels of tetanus, rubella, mumps, and paralytic polio were reported in 1985. Provisional data for 1985 is as follows:

Tetanus - A record low of 71 cases was reported. The previous low was 72 in 1981.

Rubella - A new low of 604 cases was reported which reflects a decline of 19.6 percent from the previous low of 752 reported in 1984 provisional data.

Mumps - A new low of 2,886 cases was reported in 1985 which is a decline of 4.5 percent from the previous low of 3,021 reported in 1984 provisional data.

Polio (paralytic) - A new low of 5 cases was reported. The previous low was 8 cases in 1984 provisional data.

NIOSH conducted a study of cement workers which showed no significantly increased mortality from nonmalignant respiratory diseases or lung cancer, but did indicate an elevated risk of stomach cancer mortality in a short period of follow-up.

Another study of painters suggested that they are at increased risk of lung cancer and lymphatic malignancies.

NIOSH has developed and evaluated a method to analyze filter samples of aerosols fume chromate-based paint. This air-monitoring method will aid the industrial-hygiene profession in its effort to prevent occupational cancer.

Prospective international trials have demonstrated that hepatitis B vaccine is highly effective in the prevention of mother-to-child transmission of the disease.

CDC is focusing on the prevention and treatment of influenza with licensed and investigational anti-influenza drugs. CDC has verified that an investigational drug, rimantidine, can be safely used for extended periods by nursing home residents, and is working through the ACIP to expand safe and optimal usage of the presently licensed drug, amantadine.

A case-control study of risk factors for Haemophilus influenzae type b disease in metropolitan Atlanta has been completed. Day care was a significant risk factor for occurrence of disease. Breast-feeding was protective in children under one year of age. Race was not a risk factor independent of socioeconomic status and crowding.

Eighty-six percent of the nation's laboratories offering rabies examinations participated in a CDC performance evaluation and assistance program. Initial laboratory efficiency was good (93%) and was increased to 97%.

Through an interagency agreement with the Veterans Administration, CDC staff continued work on the epidemiologic studies of the health of Vietnam veterans.

The Agency for Toxic Substances and Disease Registry (ATSDR) provided to EPA and States more than 500 health-related consultations for emergency and immediate removal response actions.

Disease Control, Research, and Training

---

1. Preventive health and health services block grant
(Title XIX of the Public Health Service Act, Sections 301, 304, 306, 307, 308, 310, 311, and 327)

1987 Authorization: $98,500,000

Budget Authority:

	1986 Appropriation		1986 Available after Sequestering	1987	Increase or Decrease
Grants	$90,958,000		$87,047,000	$89,000,000	+1,953,000
		FTE	42	42	-
Program Operations	525,000		502,000	525,000	+23,000
		FTE	6	6	-
Total	91,483,000		87,549,000 /1	89,525,000	+1,976,000
		FTE	48	48	-

/1 The 1986 available after sequestering reflects a decrease of $3,934,000 from the Congressional allowance as required by the Gramm-Rudman-Hollings Deficit Reduction Act.

Purpose and Method of Operation

This block grant provides States with funds for preventive health services to reduce preventable morbidity and mortality and improve quality of life. These grants give the States greater flexibility in deciding how available funding will be used to meet State priorities in preventive health services. Beginning in FY 1982 the following categorical programs were consolidated into the Preventive Health and Health Services Block Grant:

-- Supporting comprehensive public health services (PHS Act Section 314(d)).

-- Providing for community-based programs to help people reduce health risks and supporting programs to deter smoking and use of alcoholic beverages among children and adolescents (Health Services and Center Amendments of 1978 - Sections 401 & 402).

-- Establishing and maintaining preventive health programs to detect and prevent hypertension (PHS Act Section 317).

-- Planning, establishing, or improving emergency medical services systems (PHS Act Sections 1202, 1203, and 1204).

-- Supporting community and school based fluoridation programs (PHS Act Section 317).

-- Providing for services to rape victims and for rape prevention programs (Mental Health Systems Act Section 602).

-- Providing for home health services (PHS Act Section 339).

This block grant is intended to eliminate duplication of effort, increase service delivery efficiencies, and reduce federally imposed burdens on the States. The funds are allocated to the States, the District of Columbia, Puerto Rico, the five Insular areas (American Samoa, Guam, Northern Marianna Islands, Trust Territory, and Virgin Islands), and eligible Indian Tribes and Tribal Organizations which apply. Each area receives an allotment based on the funds received by the State in FY 1981 for the categorical programs consolidated into the block grant as a ratio to the total categorical awards to all States, Territories, and D.C. in FY 1981. The law requires that at least $3,500,000 be reserved for services to rape victims and rape prevention, which are allocated on the basis of the population.

Accomplishments

During FY 1985, all eligible entities applied for and received grant funds under the Preventive Health and Health Services Block Grant. In addition to the 57 States, Territories, and the District of Columbia, one Indian Tribe, the Santee Sioux of Nebraska, was also funded. In response to State requests, assignees were provided in lieu of cash to assist in program development and execution. These assignments were in tuberculosis control, health education/risk reduction, other prevention programs, and comprehensive public health. Technical assistance was provided to States to increase the effectiveness of their prevention programs.

Consistent with the block grant concept the jurisdictions are funding allowable programs at varying levels responding to the needs of the respective jurisdiction. Although programs have been added and some deleted, the basic core of programs previously supported with categorical funds have generally been maintained, but in many instances at different funding levels.

1987 Budget Proposal

In fiscal year 1987, $89,000,000 for grants and $525,000 for program operations is requested for continuation of the activities funded by this grant.

These funds will be used to support programs that are required to meet State priorities in preventive health services.

Impact Data	1985	1986 After Sequestering	1987
No. of grants awarded	58	59*	59*

* Includes an additional Indian tribe

BEST COPY AVAILABLE

2. Prevention Centers
(Title XVII of the Public Health Services Act, Section 1706)

1987 Authorization: $13,000,000

Budget Authority:

1986 Appropriation	1986 Available after Sequestering	1986 Revised Estimate	1987	Increase or Decrease
$1,500,000	$1,436,000	- /1	-	-

/1 The 1986 revised estimate reflects a decrease of $1,500,000 from the Congressional allowance: $64,000 as required by the Gramm-Rudman-Hollings Deficit Reduction Act and a proposed rescission of $1,436,000.

Purpose and Method of Operation

Grants would be made with academic health centers for the establishment, maintenance, and operation of centers for research and demonstration with respect to health promotion and disease prevention. These centers would undertake research and demonstration projects in health promotion, disease prevention, and improved methods of appraising health hazards and risk factors, and serve as demonstration sites for the use of new and innovative research in public health techniques to prevent chronic diseases.

1987 Budget Proposal

The funds appropriated for this activity in 1986 are proposed for rescission as part of the President's overall budget reform plan to curtail Federal Government spending.

Because of the overriding need for Federal fiscal constraint, no funds are requested in FY 1987. It is difficult to justify starting new programs, such as prevention centers, at this time. CDC currently spends about $1 million a year on cooperative agreements and contracts for similar research and demonstration projects on health promotion and disease prevention. In addition, over $1.2 billion are spent each year by other Federal biomedical research agencies on prevention research activities.

3. Sexually transmitted diseases
(Public Health Service Act, Sections 301, 304, 306, 307, 308, 310, 311, 318, and 327)

1987 Authorization: $68,000,000

Budget Authority:

	1986 Appropriation		1986 Available after Sequestering	1987	Increase or Decrease
Grants	$46,511,000		$44,511,000	$45,510,000	+$999,000
		FTE	397	397	-
Program Operations	9,774,000		9,354,000	9,943,000	+589,000
		FTE	158	158	-
Total	56,285,000		53,865,000 /1	55,453,000	+1,588,000
		FTE	555	555	-

/1 The 1986 available after sequestering reflects a decrease of $2,420,000 from the Congressional allowance as required by the Gramm-Rudman-Hollings Deficit Reduction Act.

Purpose and Method of Operation

The Centers for Disease Control provides active leadership and support for national efforts directed toward the prevention and control of sexually transmitted diseases (STD) using two methods:

1. Project grants to States - Project grants awarded to State and local health departments and appropriate public and nonprofit entities emphasize the reduction of STD morbidity and mortality. The basic control program components carried out with technical and financial assistance from CDC are: (1) screening high-risk populations for the identification of asymptomatic women with gonococcal infection; (2) controlling outbreaks of gonococcal (PPNG, CMRNG and TRNG) and other resistant organisms; (3) maintaining surveillance systems for the identification of syphilis cases among specific, high-risk populations; (4) providing sex partner referral services for patients with gonorrhea, infectious syphilis, and, to a limited extent, chlamydia; (5) establishing hospital-based surveillance systems for the identification of patients with pelvic inflammatory disease (PID); (6) providing STD facts to people at risk to prevent exposure and influence the infected to seek prompt medical care for themselves and their sex partners; (7) providing clinical skills training for medical and paramedical personnel; and (8) involving the private medical community in all aspects of STD control.

2. Program operations - STD program operations activities are those which can be accomplished only at the national level or which are more cost-effective to perform centrally rather than being duplicated in each State and territory. These activities include national disease surveillance, epidemiologic research, and the development of prevention strategies, technologies, and methods. Results of these activities and the provision of technical assistance will enable the States to implement their preventive health strategies more effectively.

   Other STD are emerging as potentially serious public health problems requiring new and/or innovative approaches to diagnostic, therapeutic, and case management services. Although the control of gonorrhea and syphilis and the prevention of their serious complications will continue to be the major focus for control efforts, chlamydia control strategies will be added as funding levels permit. In FY 1985, approximately 171,000 cases of gonorrhea and 5,500 cases of early syphilis were prevented as a result of outreach efforts. The savings from efforts to control gonorrhea in FY 1985 attributable to CDC expenditures were over $87 million. Expenditures by the Centers for Disease Control (both grants and direct operations) for gonorrhea control were $28.6 million, making the ratio of benefits to costs over 3:1.

Accomplishments

Federally-assisted State and local gonorrhea control programs were implemented in 1972. Since that year the annual increases in reported cases began to slow from 11 percent in FY 1973 to 3 percent in 1976. From FY 1976-1984 the number of cases leveled and the rates declined. In FY 1985, however, gonorrhea increased for the first time in five years. The increase (6.8 percent) is the result of a combination of factors including increases in the proportion of gonorrhea which is resistant to recommended therapy, and shifting of priority to HTLV-III antibody testing and counseling.

Reported cases of syphilis have declined from an all-time high of 575,600 in 1943 to 67,000 in FY 1985. During this same period, first admissions to mental hospitals for syphilitic psychoses have declined by 98 percent, and infant deaths caused by syphilis have declined 99 percent. The reported incidence of primary and secondary syphilis decreased in FY 1985 by 9.4 percent below the cases reported in 1984 and represents the second consecutive year of decline. An increase in the number of cases of congenital syphilis from 201 in 1984 to 310 in 1985 is attributable to improved surveillance at the national level and increased awareness of the problem of syphilis among pregnant women.

In FY 1985, the program developed and distributed policies and/or guidelines for STD control programs throughout the Nation to include: *Chlamydia trachomatis* Infections - Policy Guidelines for Prevention and Control; Quality Assurance Guidelines for Managing the Performance of Disease Intervention Specialists in STD Control; Guidelines for STD Education; and STD Treatment Guidelines, 1985.

Through outreach activities, 7.4 million women were cultured for gonorrhea, 4.1 percent (301,500) were positive and 95 percent (286,400) were located and treated. An estimated 171,000 new gonorrhea and 5,500 new syphilis infections were prevented as a result of disease intervention activities.

1987 Budget Proposal

The budget request for FY 1987 will: continue to increase the support, begun in FY 1984, for development of chlamydial control strategies; place continued emphasis on the control of gonorrhea and its severe complications; and maintain a streamlined syphilis control program focused on the prevention of congenital cases.

Grant funds will continue support for programs to prevent and control pelvic inflammatory disease including: rapid identification of PID patients seen as hospital outpatients; counseling patients to encourage adherence to treatment and post-treatment testing schedules; thoroughly interviewing patients to identify all "at-risk" sex partners; rapidly referring sex partners of patients for diagnosis and appropriate treatment; and counseling patients about appropriate prevention regimens.

Educational efforts will continue to focus on: high-risk populations, particularly STD patients; providers of medical care services; and the general public, especially adolescents and young adults. Technical assistance and consultation to State and local health departments will emphasize improving diagnostic techniques and clinical care.

Emphasis on disease monitoring, screening, sex partner-referral services, and other outreach efforts will provide STD services to an estimated 9.0 million persons, primarily adolescents and young adults. These efforts will result in the treatment of more than 650,000 syphilis, gonorrhea, and chlamydia patients and other suspects.

With the expanding body of knowledge about STD and the documented need to upgrade clinical competence among both private and public health care providers, this request will continue support of 10 geographically dispersed STD Prevention/Training Centers. These centers create a nationwide network of resources for STD -- training competent clinicians; setting high standards of clinical care; and researching new control diagnostic and therapeutic modalities. During FY 1987, more than 1,800 medical personnel will receive training in these training centers. Efforts will also continue on the further development, coordination, and evaluation of STD curricula in six medical school settings.

CDC will continue to provide STD technical assistance and consultation in: planning, developing, and implementing control technologies; reviewing and monitoring control efforts; conducting research studies and demonstrations; developing management information systems; training; and providing epidemic assistance and disease information.

CDC will continue the national focus for the identification and active investigation of special STD control problems by: monitoring the penicillin resistance of gonococci and testing strains of PPNG for resistance to other antibiotics; standardizing and monitoring the performance of laboratory testing for resistant gonorrhea; assisting in the investigation of outbreaks of gonococcal resistance; evaluating commercially manufactured laboratory reagents for penicillinase testing, serologic testing, and other STD diagnostic procedures; and serving as reference laboratory for diagnostic tests for STD in problem situations.

Efforts to standardize, expand, and upgrade the quality of data collection, analysis, interpretation, and use at the Federal, State, and local level will be emphasized through the completion of a nationwide microcomputer based STD disease information system.

CDC will support applied research and demonstration grants to identify and evaluate methods for more cost-effective disease prevention, identification and diagnosis.

Surveillance and epidemiologic research related to STD will be continued, and will direct disease-specific attention to continue research activities for chlamydial infection to better define the problem and to seek public health applications of existing and new technologies. Program operation funds directed toward genital herpes will include the monitoring of long-term toxicity and viral resistance of oral acyclovir as well as the evaluation of alternative diagnostic techniques. Human papillomavirus research will focus on the identification of risk groups and alternative treatment regimens.

Impact Data	1985	1986 after Sequestering	1987
No. of gonorrhea cases prevented	171,000	138,750	150,000
No. of gonococcal PID cases prevented	27,666	23,125	26,000
No. of infectious syphilis cases prevented	5,500	5,350	5,500
Estimated morbidity levels:			
gonorrhea	921,922	958,800	939,600
resistant gonorrhea	7,041	7,000	6,500
gonococcal PID	27,812	27,500	27,000
infectious syphilis	26,892	26,000	25,500
congenital syphilis	310	300	275

4. Immunization
(Sections 301, 304, 306, 307, 310, 311, 317, 327, 352, and 353, of the Public Health Service Act)

1987 Authorization: Grants $65,000,000
Program operations ... Indefinite

Budget Authority:

	1986 Appropriation		1986 Available after Sequestering	1987	Increase or Decrease
Grants	$47,359,000		$45,323,000	$47,666,000	+$2,343,000
		FTE	80	80	-
Program operations	8,235,000		7,744,000	8,346,000	+602,000
		FTE	117	117	-
Vaccine stockpile	4,000,000		3,828,000	-	-3,828,000
		FTE	-	-	-
Total	59,594,000		56,895,000 /1	56,012,000	-883,000
		FTE	197	197	-

/1 The 1986 available after sequestering reflects a decrease of $2,699,000 from the Congressional allowance: $2,562,000 required by the Gramm-Rudman-Hollings Deficit Reduction Act, $142,000 withheld from obligations as required by Section 515 of the Treasury-Postal Services Appropriation Act, 1986. This reduction is partially offset by an increase of $5,000 for unobligated balance carried forward from the prior year.

Purpose and Method of Operations

Appropriate administration of safe and effective vaccines continues to be the most cost-effective method of preventing human suffering and reducing economic costs resulting from vaccine-preventable diseases. The Public Health Service has established immunization as one of the 15 objectives which would significantly reduce unnecessary morbidity and mortality.

The Centers for Disease Control (CDC) uses two methods to prevent and/or control vaccine preventable diseases:

(1) Project grant support to States - Since 1963, CDC has provided project grant support to assist State and local health agencies in planning, developing, and conducting childhood immunization programs.

The grant program is aimed at achieving the 1990 objectives for immunization which are to: reduce morbidity and mortality due to vaccine-preventable diseases of childhood; maintain interruption of indigenous measles transmission; maintain 95 percent immunization levels for school children under age 15 against measles, poliomyelitis, diphtheria, tetanus, and rubella; maintain 95 percent immunization levels for school enterers and children enrolled in licensed day-care centers against measles, poliomyelitis, diphtheria, tetanus, pertussis, rubella, and mumps; and develop, test, and implement systems for use in the States to ensure that 90 percent or more of all children complete basic immunizations by age 2.

(2) Program operations - CDC carries out immunization program activities which either can be accomplished only at the national level or which are more cost-effective to perform centrally rather than being duplicated in each State and Territory. These activities include: developing national goals for the prevention and control of vaccine-preventable diseases for both children and adults and the strategies for achieving these goals; providing technical assistance and consultation in management practices and program operation methods; reviewing and evaluating State and local immunization programs; maintaining a stockpile of vaccine and jet injector equipment for use in epidemics, or in the event of disruption of the supply of vaccine; maintaining a mechanism for saving millions of dollars annually by the consolidated purchase of vaccines for State and local agencies; providing national surveillance of vaccine-preventable diseases and prompt epidemic assistance in the investigation and control of outbreaks of vaccine-preventable diseases; providing laboratory reference services; rapidly identifying problems of national significance (e.g., the identification of lots of vaccine which are of potential concern); developing recommendations for the appropriate use of vaccines; assessing national immunization levels; providing laboratory proficiency testing; conducting studies and investigations to determine the safety, efficacy, and appropriate use of new and presently used vaccines; and conducting surveillance and investigation of vaccine reactions and failures.

Accomplishments

Immunization programs make an important contribution to health cost containment efforts as well as to the quality of life of the people and communities served. In spite of the recent increases in the price of vaccines, they still have a high benefit-cost ratio. For example, the benefit-cost ratio of rubella immunization given in combination with measles vaccine is estimated to be over 14:1, and the benefit-cost ratio for polio immunization is over 10:1. This translates to an estimated savings of about $1 billion per year for polio, and $500 million per year for measles. Since 1963, over 59 million cases of measles and 19,500 cases of mental retardation have been averted, and 5,900 children's lives have been saved as a result of measles immunization.

The following morbidity patterns in reported cases have been observed since 1977:

Year	Measles	Rubella	Mumps	Pertussis	Tetanus	Paralytic Polio	Diphtheria
1977	57,345	20,395	21,436**	2,177	87	18	84
1980	13,506**	3,904	8,576**	1,730	95	8	3**
1981	3,124**	2,077**	4,941**	1,248	72**	6**	5
1982	1,714**	2,325	5,270	1,895	88	8	2**
1983	1,497**	970**	3,355**	2,463	91	15	5
1984	2,587	752**	3,021**	2,276	74	8	1**
1985*	2,704	604**	2,886**	3,275	71**	5**	2

* Provisional Data
** Record Low

Tremendous progress continues to be made in protecting our Nation's children by raising their immunization levels since a major childhood immunization campaign was initiated in 1977. The most important changes in reported disease incidence from 1977 through 1985 are the reductions in reported cases of measles, rubella, and mumps (a decrease of 96 percent, 97 percent, 87 percent respectively). No cases of diphtheria and only two cases of tetanus were reported in children under age 15 during 1985. Reported incidence of the other vaccine-preventable diseases reflect typical annual fluctuations, but continued control of those diseases. When reported incidence reaches such low levels, a few outbreaks can account for a large proportion of the total number of reported cases. For example, half of the measles cases reported in 1985 occurred in four States.

Nationally-weighted immunization levels for children entering school for the 1984-1985 school year were: 98 percent for measles, mumps, rubella and polio, and 97 percent DTP-Td. Except for a few discrete outbreaks, indigenous measles has essentially been eliminated from the United States. In 1985, 93 percent of the Nation's 3,137 counties reported no measles at all.

1987 Budget Proposal

Resources requested for 1987 will be used to continue the efforts of official health agencies in all 50 States and 12 areas and Territories to ensure the immunization of preschool children and prevent the build-up of new pockets of susceptible children and to eliminate measles, rubella, and congenital rubella syndrome from the United States. Major goals for 1987 related to the vaccine-preventable diseases are to: maintain the high immunization levels of children entering school; increase age-appropriate immunization levels of preschool children; maintain present levels or continue the downward trend in reported cases of measles, rubella, mumps, polio, diphtheria, pertussis, and tetanus; maintain surveillance and continue research about the safety, efficacy, and appropriate use of vaccines; and increase the appropriate immunization of adults. States and communities will continue to be urged to broaden immunization requirements to include entry into college. Increasing State and local support will also be necessary for the essential activities of surveillance, investigation, and program coordination.

The rapidly increasing price of vaccine continues to be a problem. The most recent vaccine price increase was 94% for polio in January, 1986. In fiscal year 1987, $47,666,000 is requested to continue the grant program. Of this amount, $32,882,000 will purchase the same proportion of doses of measles, rubella, mumps, and polio vaccine as was purchased in 1986. The remaining $14,784,000 will be used by the States to offset the increasing cost of DTP vaccine, and/or to fund State operations which include the system to ensure that the vaccine reaches the appropriate children and the surveillance necessary to maintain the high immunization levels.

Impact Data	1986	1986 after Sequestering	1987
Public Sector Doses of Polio, Mumps, Measles, and Rubella Vaccine Purchased with Grant Funds (in millions)	12.7	12.7	12.7
Public Sector Doses of DTP Vaccine Purchased with Grant Funds (in millions)	3.5	3.5	*

* States will have the option to purchase DTP vaccine or fund State immunization program operations with $14.8 million of Federal immunization grants.

Even though the request does not include funds for the expansion of the vaccine stockpile, completion of the vaccine stockpile remains a high priority. First, new vaccines for DTP and haemophilus influenzae b are being developed which are likely to replace the vaccines currently in use. Second, a second manufacturer of OPV is expected to enter the market. Third, it is also possible that a second company may enter the MMR vaccine market. Fourth, the administration has transmitted to the Congress legislation to limit preventive and non-economic damage awards against vaccine manufacturers to help insure that companies can obtain liability insurance. Because of these issues and the concerns about the efficiency of Federal expenditures, it is felt that expansion of the stockpile beyond 1986 should be delayed until these issues are resolved (1988 or 1989).

---

5. Infectious Diseases
(Sections 301, 304, 306, 307, 308, 310, 311, 317, 327, 352, 353, and 1102 of the Public Health Service Act)

1987 Authorization: Indefinite

Budget Authority:

1986 Appropriation	1986 Available after Sequestering	1986 Revised Estimate	1987	Increase or Decrease
$106,698,000 /1	$39,944,000 /1	$35,159,000/1/2	$36,358,000 /1	+$1,199,000
	FTE	713	713	-

/1 Funds for AIDS activities in 1987 in the amount of $45,800,000 are budgeted under the appropriation "Priority Disease Control and Research" for the Office of the Assistant Secretary for Health. Net available in 1986 after sequestering; $62,133,000 and in 1986 Revised Estimate; $50,285,000.

/2 The 1986 revised estimate reflects a decrease of $71,539,000 from the Congressional allowance: comparative transfer of Acquired Immunodeficiency Syndrome (AIDS) program to the Public Health Services Management appropriation in the amount of $50,285,000, a decrease of $4,588,000 as required by the Gramm-Rudman-Hollings Deficit Reduction Act, a decrease of $33,000 withheld from obligations as required by Section 515 of the Treasury-Postal Services Appropriation Act, 1986, and a proposed rescission of $16,633,000.

Purpose and Method of Operation

CDC's efforts in infectious disease prevention are to develop new or improved prevention and control methods and techniques and to accelerate the general application of accepted prevention technology. These activities complement epidemic services and provide a major aspect of the public health base which is vital to CDC's emergency response. Specifically, the major objectives include: (a) improve prevention and control technology through research designed to develop or refine technical methods and techniques related to diagnosis and prevention of disease; (b) develop and apply epidemiologic and laboratory technology to prevent and control AIDS and to reduce its morbidity and mortality; (c) develop prevention strategies for known and unidentified agents of enteric diseases; (d) reduce, by 1990, the annual reported incidence of nosocomial infections in acute-care, long-term care, and residential-care hospitals by 20 percent of what otherwise would pertain in the absence of hospital infection control programs; (e) ensure, by 1990, that 95 percent of licensed patient care facilities are implementing the recommended practices for controlling nosocomial infections; (f) reduce, by 1990, the annual estimated incidence of hepatitis B to 20 per 100,000 population; (g) reduce, by 1990, the annual reported incidence of bacterial meningitis to 2 per 100,000 population; (h) reduce, by 1990, the annual estimated incidence of pneumococcal pneumonia to 115 per 100,000 population and the incidence of pneumococcal bacteremia to 7 per 100,000 population; and (i) reduce, by 1990, the annual reported incidence of tuberculosis to 8 per 100,000 population.

Accomplishments

CDC scientists found the homing mechanism used by the AIDS virus to infect white blood cells, a discovery which improves chances that a vaccine can be developed against the deadly disease. The work involves isolating tiny surface molecules on the virus as well as the matching molecules found on the type of blood cells which the virus attacks.

The AIDS Program evaluated, in cooperation with the Atlanta Red Cross, the sensitivity and specificity of the Abbott serologic test (ELISA) to detect antibody to HTLV-III through the testing of 75,000 blood units. The results were correlated with other tests for HTLV-III antibodies, the presence of virus in the blood, and the donor's history. The study showed that the combination of repeatedly positive ELISA and a positive confirmatory test (Western blot) were highly correlated with other epidemiologic and laboratory evidence of HTLV-III infection. The study validated the use of this serologic testing procedure by U.S. blood and plasma collection facilities. In combination with voluntary avoidance of donation of blood and plasma by members of high-risk groups recommended by PHS on March 4, 1983, the use of this test will effectively reduce the risk of AIDS transmission through the nation's blood system, preventing illness and deaths due to the syndrome.

In the AIDS Program study of family members of AIDS patients at Montefiore Medical Center in New York City, a total of 101 household contacts of 39 AIDS patients have been evaluated. Other than the expected transmission between sexual partners and from infected mother to infant child, no evidence of HTLV-III transmission within the household was found. This study provides both strong evidence that "casual" transmission of HTLV-III does not occur and important support for guidelines on the care of AIDS patients and the education of children with AIDS.

Developed a microcomputer software system for the interactive entry, analysis, and transmission to CDC of nosocomial infection surveillance data by National Nosocomial Infections Study (NNIS) hospital infection control personnel. Participating hospitals are thereby able to edit and analyze infection control data rapidly and efficiently and to tailor the analyses to their own needs while meeting CDC's needs for high-quality national data on nosocomial infections.

Follow-up of participants in the CDC sponsored hepatitis B vaccine trials continued to show excellent protection against infection after 5 years.

Prospective international trials have demonstrated that hepatitis B vaccine is highly effective in the prevention of mother-to-child transmission of the disease.

CDC is focusing on the prevention and treatment of influenza with licensed and investigational anti-influenza drugs. CDC has verified that an investigational drug, rimantidine, can be safely used for extended periods by nursing home residents, and is working through the ACIP to expand safe and optimal usage of the presently licensed drug, amantadine.

A case-control study of risk factors for Haemophilus influenzae type b disease in metropolitan Atlanta has been completed. Day care was a significant risk factor for occurrence of disease. Breast-feeding was protective in children under one year of age. Race was not a risk factor independent of socioeconomic status and crowding.

Eighty-six percent of the nation's laboratories offering rabies examinations participated in a CDC performance evaluation and assistance program. Initial laboratory efficiency was good (93%) and was increased to 97%.

CDC has introduced a 3 step plan to hasten the elimination of tuberculosis from the U.S.: (1) Intensification of known prevention and control measures; (2) Research to develop more effective biotechnical tools; and (3) Technological Transfer of new tools as developed. A national conference of scientists met and produced a plan for future tuberculosis research. CDC is investigating the relationship between AIDS/HTLV-III infection and the increase in tuberculosis in two areas of the country. CDC and the Office of Migrant Health worked to publish a booklet on tuberculosis among migrant workers. A clinical trial is undergoing preliminary analysis which should lead to a national recommendation for 6-month rather than 9-month therapy; a statement recommending preventive therapy of 6-9 months duration will be issued in FY 1986.

1987 Budget Proposal

In FY 1987 $36,358,000 is requested for the improvement and implementation of infectious disease activities.

These funds will be used for activities designed to prevent or control the spread of infectious diseases by: identifying needed improvements; developing new or modified prevention strategies; maintaining a capability to respond to outbreaks of many diseases that seldom occur; evaluating new technologies; and transferring appropriate new technologies. Through technology transfer, CDC will modify public health practice by helping to ensure that public health personnel possess the skill and knowledge necessary to adequately perform their infectious disease control and prevention functions. Some of the programs in this activity are highlighted in the following narrative.

Hepatitis B - The hepatitis B virus (HBV) infects the liver acutely and may lead to chronic hepatitis and liver cancer. In 1985, the annual incidence of hepatitis B infections was estimated at 69 cases per 100,000 population. The objective is to reduce the occurrence to 20 cases per 100,000 population by 1990. Approximately 200,000 new infections occur per year, requiring 50,000 hospitalizations and result in 4,000 deaths. Direct medical and work-loss costs from hepatitis B total over $350 million per year. An available effective hepatitis B vaccine is targeted at known high-risk segments of the population such as health care workers, homosexual men, the institutionalized mentally retarded, and intravenous drug users. The impact of vaccinating high-risk persons is unknown since 40 percent of acute hepatitis B cases are not traceable to a recognized source of infection. Vaccine impact can only be assessed through vigorous surveillance and large-scale vaccine demonstration trials. In Alaska the annual incidence of HBV infection is as high as 33 percent in some homes and villages. The incidence of HBV-associated sequelae such as primary hepatocellular carcinoma (PHC) and vasculitis is 5 and 75 times that of U.S. whites. The incidence of PHC in Alaskan Eskimo males is 11.2 cases per 100,000, a rate five-fold higher than that seen in U.S. white males.

To reach the 1990 objective of reducing the annual incidence of hepatitis B, CDC will: (1) determine the existence of groups at high risk of hepatitis B infection, other than those currently recognized; (2) obtain incidence, prevalence, and cost data on cases of chronic HBV and sequelae from a defined, general U.S. population base; (3) implement a vaccine demonstration project; (4) evaluate newer hepatitis B vaccines in two high-risk populations; (5) determine the duration of vaccine-induced antibody in patients receiving the hepatitis B vaccine in Alaska; and (6) reduce the incidence of hepatitis B infection in Alaskan Natives from 8 percent to less than 2 percent.

Hospital Infections - Nosocomial (hospital-associated) infections are estimated to occur in 5 percent of all patients admitted to U.S. hospitals, thus accounting for approximately two million nosocomial infections per year. However, the estimated incidence may reach as high as 15 percent or more in some individual hospitals. A unique feature of nosocomial infections is that, amid the rapidly increasing technological complexity of the hospital environment, the risk factors that strongly predispose patients to infection are constantly changing. This necessitates constant surveillance at the hospital and national levels to identify new risks as they occur. In 1975, it was estimated from prospective studies in several different types of hospitals that a nosocomial infection adds an average of four days and $600 to an affected patient's hospital bill. This amounts to over $1.2 billion (1975 dollars) in additional hospital expenses for infections acquired in hospitals nationwide. An adjustment of the 1975 estimated cost to a 1984 dollar cost yields an annual cost estimate in excess of $2.5 billion. Since nosocomial infections are more frequent among elderly patients and among the poor, the extra charges attributable to this problem are borne disproportionately by the federally financed reimbursement programs, Medicare and Medicaid. Approximately 32 percent of nosocomial infections are preventable, particularly those that occur in epidemics or that are associated with specific diagnostic or therapeutic procedures performed in modern hospitals.

To reach the 1990 objectives of reducing the incidence of hospital infections and ensuring implementation of recommended control practices, CDC in 1987 will continue to: (1) assess the effect of the Guidelines for the Prevention and Control of Nosocomial Infections on infection control practices; (2) expand the data base on nosocomial infections by at least 10 percent; (3) determine the morbidity and mortality associated with nosocomial infections caused by antimicrobial resistant bacteria; and (4) determine the incidence of infections caused by selected nosocomial pathogens and the extent to which antimicrobial resistance is emerging.

Tuberculosis - CDC will continue its tuberculosis program of intensification, research, and technology transfer toward the elimination of tuberculosis as a public health problem. The collection and analysis of morbidity and program management reports from States, territories, and large cities will continue. Special studies of tuberculosis mortality and tuberculosis in children will be done to determine the proportion which are "preventable" and will respond to requests for investigating tuberculosis among high risk groups including patients with HTLV-III infection. Medical, epidemiologic, statistical, and programmatic consultation and program assistance will be directed to high incidence areas and areas with special problems such as TB/AIDS, drug resistance, a large influx of refugees with tuberculosis, the homeless, and elderly populations in nursing homes. Close surveillance and analysis of drug resistance in 15-20 States and cities will continue. Efforts will continue to develop, refine, and assist in the implementation of more effective diagnostic tests. In FY 1987, CDC will: actively encourage 6-month therapy; have begun a new trial of rifabutine for the treatment of drug-resistant TB and pulmonary M. avium complex disease; and have developed a protocol for a short-course (3 month) preventive therapy clinical trial. Continued progress will be made on the recommendations from the national tuberculosis research conference towards improving methods in five specific areas: diagnosis; treatment; defining which of the infected are at greatest risk of developing disease; prevention of disease among the infected; and prevention of infection among non-infected persons.

The 1985 reduction in decline (-2.5% in 1985, compared to -6.7% in 1984) of tuberculosis cases is being investigated to support the major hypothesis that HTLV-III infection of persons already infected with the tubercle bacillus has caused an increase of tuberculosis in some areas. In addition, outbreaks of tuberculosis among the homeless may be contributing to the leveling off in tuberculosis morbidity.

Impact Data	1985	1986 Revised	1987
No. of TB cases reported*	21801**	20493	19263
TB case rate per 100,000 pop.*	9.13**	8.55	8.04

* Assumes a 6% annual reduction
** Provisional data

The funds appropriated for TB grants in 1986 are proposed for rescission as part of the President's overall budget reform plan to curtail Federal Government spending, and no funds are requested in 1987. Alternative funds from the Preventive Health and Health Services Block Grants (funded at $89 million in 1987) and the Refugee Preventive Health Program (funded at $10.4 million in 1987) are available for this purpose. CDC will continue to provide consultation, training, disease surveillance, operational research, and other technical assistance to the States in TB control and prevention.

Pneumococcal Disease - An estimated 400,000 cases of pneumococcal pneumonia occur in the U.S. annually. The true incidence of pneumococcal disease is uncertain because routine diagnostic methods such as sputum culture are neither sensitive nor specific. In the elderly and those with other underlying diseases, the case fatality ratio is 25 to 35 percent. Acute lower respiratory tract disease, primarily pneumonia, is the leading cause of infectious disease mortality in the U.S., and one of the two principal causes of mortality in children less than five years old in developing countries. The portion due to pneumococcus is unknown. A vaccine is now available for control of the disease. Major questions remain regarding the effectiveness of the current vaccine for the elderly and those with underlying disease, the group at highest risk of disease. The vaccine is not effective in children less than two years old, a major potential target group in developing countries. Control of morbidity due to pneumococcal disease is complicated by the increasing frequency of resistance to commonly-available antimicrobial agents.

To achieve the 1990 objective to reduce pneumococcal pneumonia and bacteremia, CDC will: (1) evaluate the efficacy of currently available pneumococcal vaccine for prevention of disease in the U.S.; (2) determine the status of antimicrobial resistance among pneumococci in the U.S.; (3) determine the role of *Streptococcus pneumoniae* as a cause of community-acquired pneumonia in the U.S.; and (4) develop a national strategy for pneumococcal disease prevention.

Bacterial Meningitis - Bacterial meningitis is a life-threatening infection of the central nervous system. Approximately 15,000-20,000 cases occur annually in the U.S., caused predominantly by *H. influenzae*, *N. meningitidis*, *S. pneumoniae*, and group B streptococci. Neonates and the elderly are at greatest risk.

H. influenzae infections are major causes of pediatric morbidity and mortality with an estimated 10,000 cases of meningitis and 500 deaths annually. In addition to meningitis, an approximate equal number of persons have other forms of invasive *H. influenzae* type b (Hib) disease: pneumonia, cellulitis, osteomyelitis, septic arthritis, and epiglottitis. More than 95 percent of all invasive disease occurs in children less than five years of age and greater than 50 percent occurs in children less than 18 months of age. Mortality from Hib meningitis is 5-10 percent, and the morbidity among survivors is substantial with approximately 25 percent having residual seizures, retardation, deafness or learning disability. Children in day-care centers are at increased risk of primary *H. influenzae* disease. Of all the population groups studied in the U.S., the Alaskan Eskimos have the highest incidence of Hib disease. A currently licensed polysaccharide vaccine is efficacious in children over 18 months of age, and a vaccine is being developed for all age groups, especially those under 18 months who are at highest risk of disease.

To achieve the 1990 objective of reducing the annual incidence of bacterial meningitis, CDC will: (1) institute a laboratory-based surveillance system to determine the incidence of bacterial meningitis and impact of control measures; (2) determine risk factors for occurrence of bacterial meningitis which will facilitate designing and implementing control strategies; (3) develop control strategies to reduce by at least 40 percent the expected occurrence of bacterial meningitis in the contiguous States; and (4) complete an efficacy trial of newly developed *H. influenzae* vaccine in Alaska.

Enteric Diseases - Viral, bacterial, and parasitic enteric diseases are a major cause of morbidity and mortality in the U.S. and in developing countries. In the U.S. there are 30,000 to 50,000 pediatric hospitalizations for acute viral gastroenteritis. Rotavirus accounts for 30-50 percent of pediatric hospitalized cases. Rotavirus vaccines, recently developed and presently being tested in clinical trials, provide the opportunity to prevent cases of rotavirus associated gastroenteritis. The etiology of 30-50 percent of cases of acute gastroenteritis remains unknown.

The bacterial enteric diseases cause an estimated 70 million cases of illness (29,917 per 100,000 population) and 7,000 deaths per year in the U.S. Many different bacteria cause these diseases, but the most important of these, based on disease incidence, case-fatality ratios, and preventability, are Salmonella (2 million cases; 2,000 deaths per year in the U.S.), Campylobacter (2.1 million cases; 2,100 deaths), Shigella (300,000 cases; 600 deaths), E. coli (200,000 cases; 400 deaths), and Vibrio species (10,000 cases; 400 deaths). The direct costs (medical costs and medications) for bacterial enteric infections are estimated to exceed $1 billion, while indirect costs (e.g., lost work, lost years of life) are probably at least twice that figure.

The three principal protozoan enteric diseases are amebiasis, giardiasis, and cryptosporidiosis. Enteric protozoal diseases are being recognized with increasing frequency in the U.S. Collectively, these parasites affect an estimated 4 million Americans. The prevalence is generally higher, and the disease is generally more severe, in children. These diseases are a significant problem in day-care centers. In the U.S., the costs of diagnostic tests, hospitalization, drug therapy, and loss from work, are estimated to be over $120 million. E. histolytic and Cryptosporidia pose difficult diagnostic problems. The present lack of knowledge of strain virulence requires that all E. histolytic infections be treated, irrespective of symptoms. No drug has been found that is safe and effective for treating cryptosporidiosis.

Technical Assistance - The focus of consultation and technical assistance will be to ensure that State and local preventive and control efforts are directed toward high priority health problems (i.e., those targeted in the 1990 Objectives for the Nation); are consistent with state of the art intervention strategies; include the identification of essential activities involved in achieving program objectives; and incorporate measures to remove or minimize obstacles (e.g., structural or motivational problems) which may interfer with achievement of the objectives.

6. Chronic and Environmental Diseases
(Sections 301, 304, 306, 307, 308, 310, 311, 327, 352, 353, and 1102 of the Public Health Service Act)

1987 Authorization: Indefinite

Budget Authority:

	1986 Appropriation	1986 Available after Sequestering	1986 Revised Estimate	1987	Increase or Decrease
	$30,425,000	$29,065,000	$23,323,000 /1	$24,425,000	+$1,050,000
		FTE	426	426	-

/1 The 1986 revised estimate reflects a decrease of $7,102,000 from the Congressional allowance: $1,308,000 as required by the Gramm-Rudman-Hollings Deficit Reduction Act, $52,000 withheld from obligations as required by Section 515 of the Treasury-Postal Services Appropriation Act of 1986, and a proposed rescission of $5,742,000.

Purpose and Method of Operation

Premature death, illness, and injuries caused by exposure to environmental hazards, or by personal, behavior are among the most difficult problems facing Federal, State, and local health officials. Since prevention is based on: avoiding or reducing exposures to hazards; early detection of disease to avoid complications; and changing risk factors which can help to prevent occurrence and progression of disease, CDC uses its expertise and existing capacities to address:

1. Preventable environmental diseases associated with:
   - o Man-made hazards such as pesticides, herbicides, toxic chemicals, injuries, and radiation. Over 7,000 incidents have occurred during the last five years.
   - o Environmental or related factors which cause cancers, birth defects, and chromosome or other genetic damage.
   - o Natural hazards such as radiation, climatic, geologic, and weather phenomena such as heat waves, cold waves, volcanoes, or hurricanes.
2. Preventable child and adult chronic diseases associated with:
   - o Health-related behavior such as smoking, physical inactivity, lack of exercise, poor nutrition, sexual lifestyles, and overweight. Over 360,000 preventable deaths occur each year in this category.

- Access and use of preventive health services (e.g., prenatal care, pap smear testing, colon cancer screening, mammography, and hypertensive screening).

3. Preventable child or adult injuries and death associated with trauma outside the workplace:

   - Unintentional injuries associated with injury-related behavior (e.g., child tap water scaldings, poisonings, and older adult falls and burns). Over 87,000 premature deaths occur in this category.

   - Intentional injuries such as teenage suicides and young adult homicides.

The programs supported in this activity give high priority to health areas designated as key to the achievement of the 1990 national prevention objectives:

- Accident prevention and injury control.

- Toxic agent and radiation control.

- Control of stress and violent behavior.

- High blood pressure control.

The programs directed toward the goals of this activity are carried out through varying mixes of the following public health functions:

1. Surveillance and epidemiologic evaluation of specific exposure situations, disease clusters, or to identify risk factors and to recommend intervention or prevention strategies.

2. Laboratory technology designed to test for the presence of hazardous substances in human tissues and the sub-clinical or metabolic effects of such exposures.

3. The development, packaging, and transfer of the above epidemiologic and laboratory support to State, local, and other health professionals responsible for chronic disease and environmental health protection programs.

4. Technology transfer to build capacity of State and local health agencies to conduct health education, health promotion, risk reduction, injury control, chronic disease prevention and control, and environmental hazard reduction.

The nationally developed strategy for disease prevention, as articulated in Healthy People and Promoting Health/Preventing Disease: Objectives for the Nation, identifies very specific roles for CDC, as well as other PHS agencies, in dealing with chronic disease problems.

While multiple agencies have responsibilities in areas such as cancer, diabetes, alcohol misuse, violence, and injuries, the roles and implementation responsibilities assigned to each agency are clear, well-defined, coordinated, and un-duplicative.

CDC's major roles are: disease/injury prevention and control, with emphasis on the primacy of prevention, and capacity building at the State and local levels; to assist in the application of cost effective prevention strategies at the local level; chronic disease control; surveillance and epidemiological research; and the translation of findings from NIH, CDC, etc., into practical cost-effective applications to prevent unnecessary morbidity and premature mortality.

A contemporary approach to disease prevention requires close interaction between infectious disease and chronic disease control programs. Infectious agents are epidemiologically linked to some chronic diseases, such as arthritis, cirrhosis, some cancers, and AIDS. In other instances, the etiology is unknown. CDC frequently undertakes an investigation of a public health emergency in which it is not clear if the cause is an infectious agent, exposure to a toxic agent in the environment, or interaction with a behavioral factor such as smoking or alcohol use. Recent well-known examples are: AIDS, toxic shock syndrome, legionnaires disease, and cancer clusters.

Determining the etiology of these types of outbreaks and implementing preventive measures, requires CDC scientists to have expertise in chronic disease methodologies, the ability to evaluate human exposure to environmental agents, as well as expertise in infectious disease control. To provide the broad base of expertise and technical assistance demanded by State and local health agencies, CDC retains qualified epidemiologists, laboratorians, and toxicologists, who have experience in conducting studies and developing and implementing prevention methods in all of these areas.

Accomplishments

Reviewed plans to transport, test, and dispose of lethal chemical agents with respect to any hazards to public health and safety which such activities may have posed and recommended what precautionary measures were needed to protect the public health and safety.

CDC reviews and responds annually to an average of 250 environmental impact statements for all Federal projects and non-Federal projects utilizing Federal monies as defined by the National Environmental Policy Act.

The first phase of a cervical cancer project in Southeastern Kentucky has been completed. Preliminary data analysis, design, and pilot testing of an interview questionnaire for use in evaluating knowledge, attitudes, and practices with regard to Pap smear testing, sample selection, and initiation of the actual interview process were included.

Completed the laboratory analysis of the Hispanic-HANES Survey in January 1986. The survey used a 12,000 person subset of the Hispanic population to determine the general health and nutritional status of hispanics in America. Results of the survey are being checked, verified and analyzed prior to their release and publication.

In 1983, there were 8,732 deaths from congenital anomalies in the United States, which represented 21.4 per cent of all infant deaths. In order to maintain a case registry for epidemiologic and genetic studies, and to monitor the occurrence of malformations in the five county Atlanta region, twenty-seven thousand births were monitored for birth defects under the Metropolitan Atlanta Congenital Defects Program (MACDP).

New laboratory tests needed by physicians to assess risk and select appropriate intervention methods for coronary heart disease patients are being developed, evaluated, and standardized.

Two projects to prevent injuries among the elderly and in an economically-depressed minority population were continued with two local health departments. For one project the design of the surveillance system was completed. For the second project the surveillance system was established and the danger areas of the home identified, providing the information needed to design studies leading to intervention and prevention activities.

Conducting approximately 40 studies to measure the toxic effects of hazardous substances in humans including: arsenic, polychlorinated biphenyls, lead, toluene, radon, and dioxin. Findings which show that exposure or health effects have occurred allow appropriate action to be taken. On the other hand, findings which show that there have been no toxic effects from potential or actual exposure at the site are also very important, as they calm the public's fears, and prevent the need for further studies (and further expenditures).

Continued following a group of 4,000 persons exposed to polybrominated biphenyls in Michigan to ascertain what, if any, health problems result.

In the area of diabetes, developed guidelines for prevention of poor pregnancy outcomes, demonstrated the efficacy of education programs, disseminated guidelines for patient and professional education, investigated mortality among insulin pump users, developed public health strategies for the prevention of blindness and amputations due to diabetes and for coexisting diabetes and hypertension, initiated sentinel health event surveillance, implemented standards of care in health services delivery programs, emphasized hypertension control in diabetics, and stimulated third party coverage for outpatient education.

Behavioral Risk Factor Surveillance System (BRFSS) is now used by 25 States and D.C. covering 59 percent of the U.S. adult population. States have used this data to establish priorities for programs directed at key health behaviors -- smoking, obesity, uncontrolled hypertension, heavy drinking, lack of seat belt use, and sedentary lifestyle.

In response to requests from State health departments, CDC implemented a technical assistance program called a Planned Approach to Community Health (PATCH) which provides States with a community-based framework for focusing health promotion resources on major health problems addressed in the 1990 Health Objectives for the Nation. Among the behavioral risk factors that will initially be addressed this year are cigarette smoking, sedentary lifestyle, chronic drinking and seat belt use.

The School Health Education Evaluation project established that school health education has a measurable and beneficial influence on knowledge, attitudes, and practices of school children in 10 health related areas. The CDC school health curricula, "Growing Health", contributed to a minimum of 4,065 7th grade students not adopting the practice of smoking last year who would have otherwise.

1987 Budget Proposal

In FY 1987, $24,425,000 is requested for the chronic and environmental disease activities with emphasis on researching, developing, and initiating through other health agencies and individuals, prevention programs to improve the health and the quality of life of the American people.

These funds will be used to support projects related to these prevention and control needs and will include:

Environmental Emergency Response - CDC maintains a response system for responding to emergency situations involving biological, chemical, radiologic, and environmental hazards. The response system also provides for CDC coordination with other Federal agencies, State and local governments, and the private sector in responding to emergencies. This core of technologic and scientific expertise, when properly coordinated, provides for cost-effective, non-duplicative, efficient, and rapid response. Prevention and control strategies developed through research and as a result of actual experience in emergency situations are documented and transferred to other health professionals for application.

Public concern (stimulated by reports of incidents such as the release of methyl isocyanate near Institute, WV or hydrofluoric acid near Gore, OK) regarding illnesses which may result from exposure to hazardous materials and radiation in the environment result in demands for examinations, testing, epidemiologic studies, and other diagnostic evaluations of large numbers of persons living in areas of contamination. The emerging technology, particularly in laboratory detection of elevated levels of heavy metals and toxic organic compounds in people and the measurement of metabolic changes resulting from these exposures, are becoming available to be applied to incidents where these compounds are found in community water, food supplies, or in the air or soil in concentrations considered to pose a health hazard. Cooperative efforts with State and local health officials, medical schools, and concerned citizens insure that scarce resources are targeted in a coordinated fashion. Communities are assisted in the development of guidelines to prevent or minimize the risk of environmental health emergencies by better planning for transportation, holding, and disposal of toxic or hazardous substances, and improved training for emergency personnel. The core of medical, epidemiologic, laboratory, and other technical staff with experience in responding to threats to public health from environmental exposures will be maintained to assist in emergency response, to provide expert consultation, and to provide laboratory backup to State and local governments. This service is required since many States find it uneconomical to provide these services in this complex and rapidly developing field.

Injury Prevention - Activities related to the 1990 national injury prevention objectives will receive high priority. Resources will be utilized to: (1) promote the implementation of strategies to reduce drownings and to reduce morbidity, mortality, and the substantial medical costs borne by the Federal Government which result from non-work related motor vehicle crashes, falls, burns, and poisonings, all disproportionately occurring among children, the elderly, and the poor; (2) establish and maintain liaison with Federal agencies and national organizations with injury control responsibilities to insure coordination of ongoing injury prevention and control efforts, as well as, to identify ways in which other agencies can incorporate injury control objectives into their priorities; and (3) affirm its endorsement of injury prevention through active participation in national, regional, and State level functions where opportunities exist to promote this program. Liaison with appropriate agencies and organizations will be maintained to assure their cooperation. Informational, educational, and promotional activities will be maintained through the continued support of an injury information dissemination system. States and communities will be encouraged and assisted in developing and supporting locally funded injury surveillance systems and injury control programs in order to accelerate progress in the achievement of national objectives.

Technology Transfer - Chronic diseases and environmental health problems are increasingly recognized as a critical problem, often resulting in severe physical and emotional impairment and requiring a major expenditure of funds for providing care to individuals with these debilitating health problems. The full value of advances in the prevention of chronic diseases and environmental health problems is not realized until they are transferred into practice. In FY 1987, CDC will identify, analyze, develop, and implement practical solutions for problems that interfere with the achievement of objectives for the prevention and control of chronic disease programs, laboratory diagnosis of environmental diseases, and provision of environmental/technical expertise in prevention and control of environmental diseases. CDC will also give increased emphasis to developing the States' capacity to implement training and performance-based management systems developed by CDC. The greater accessibility of training, that is technically accurate, up-to-date, and of demonstrated effectiveness, will enable personnel to acquire the skills needed for managing effective environmental disease control programs.

Diabetes - There are 5.8 million people with known diabetes in the United States; there may be an equal number as yet undiagnosed. Annually over 300,000 persons with diabetes die. Diabetes consumes 25 million hospital days, and costs nearly $8 billion in direct medical expenditures. Diabetics have 25 times the risk for developing blindness and 17 times the risk for developing kidney failure as non-diabetics. Over two million diabetics require hospitalization each year and spend twice as many days in the hospital as non-diabetics. As part of the national diabetes program effort, CDC will conduct operational research and surveillance; provide consultation and training to State and local health departments to assist them in reducing morbidity and mortality; and provide national leadership in the formulation and promotion of preventive strategies, policies, and recommendations for screening, patient and professional education, and interventions for the prevention of complications.

A 1986 rescission is proposed to discontinue the State diabetes projects, and no funds are requested in 1987. Current State diabetes control projects have had Federal developmental support for 6 to 8 years ($5 million in 1985). Now these demonstration projects should be continued by the States or other third-party payment sources which have also benefitted financially from their success. Sufficient knowledge and experience is available, and States can use alternative funding sources to continue these activities. CDC will continue to provide technical assistance to States seeking to implement diabetes control programs.

Community Health Promotion - A core staff of medical epidemiologists, health educators, behavioral scientists, and other health professionals support the surveillance, analysis, evaluation, and technical assistance to State health promotion/risk reduction programs aimed at the personal health behaviors outlined in the National prevention objectives for 1990: violence; physical fitness and lack of exercise; nutrition; smoking; substance abuse; uncontrolled high blood pressure; unintended pregnancy; and childbirth. These activities are directed toward influencing pre-disease events so that the physical, emotional, and economic costs of chronic conditions are avoided by preventing the conditions from occurring. Activities include:

- Technical assistance to State and local health agencies, enabling them to involve a broad cross-section of community members in identifying priority health problems, setting measurable objectives for reducing risk factor behaviors, selecting and implementing appropriate interventions, and assessing the quality and impact of their health promotion/risk reduction efforts. Such efforts may include a wide variety of intervention strategies ranging from comprehensive school health programs, smoking cessation programs for pregnant women to reduce the impact of low birthweight on infant mortality, to media campaigns. Assistance is provided to assure that intervention strategies are selected on the basis of demonstrated effectiveness in line with resource availability.

- Behavioral epidemiology, program evaluation, and surveillance data provide the basis for targeting and refining intervention strategies, and they enable public officials and decision makers to support the allocation of limited health resources for health promotion/risk reduction programs.

- Assistance to participating States to enable them to assess the relevance of health risk factors associated with premature death and disability (Behavioral Risk Factor Surveillance System) as a means of planning more effective community interventions.

- Assistance targeted at improving the health of children and adolescents by reducing their risk of health problems and increasing their awareness of risk factors such as smoking, driving and alcohol, etc. The HHS prevention strategy emphasizes health education for youth in schools but not through direct support for school health education activities, which are funded at the community level. Rather, CDC efforts are aimed at improving educational resources and strengthening the health education capacity of State departments of education and public health and other professional, voluntary, and private sector organizations.

CDC's analysis shows that school health education can reduce 7th grade smoking by 37%. States have recently begun to work in this area, and seek CDC's assistance. Already, more than 79,000 teens and 1.12 million children (grades K-7) are now receiving instruction through CDC's nationally recognized and validated school health curriculum.

Violence - Each year, suicide and homicide claim nearly 50,000 lives, a substantial increase over the past 2 decades. CDC is examining the epidemiology of personal violence to characterize who are the groups at highest risk, and what are the factors that increase or decrease risks. The aim of this inquiry is to ascertain educational and risk reduction measures that public health agencies can adopt to help lower individual risks.

Nutrition - To assist States in targeting their nutritional programs and improving their effectiveness, CDC will:

- Provide assistance to States, as part of the National Nutrition Monitoring Plan, to develop and maintain a nutritional status surveillance system. The purpose of the system is to enable States to monitor and reduce the prevalence of major nutrition-related health problems in defined high-risk groups (e.g., children, pregnant women, blacks, Native Americans, etc.), and to take appropriate public health responses whenever problems are detected.

- Conduct epidemiologic investigations to examine the nutritional status of specific high-risk and low income minority groups and to define the relationships between nutritional status and a variety of health outcomes (e.g., infant growth and morbidity). The information is used to plan, implement, and evaluate specific interventions directed towards high-risk populations.

- Provide laboratory support for the nutrition program including evaluating the role of vitamins and essential elements in human metabolism. This has direct relationship to the environmental health and chronic disease service programs since many of the essential elements (such as zinc and cadmium) can be toxic in high doses, and certain heavy metals, particularly lead or cadmium, have no known benefit but are present in the environment and frequently cause illness.

Designer Drugs Study - A 1986 rescission is proposed for the funds appropriated for the designer drugs study as part of the President's overall budget reform plan to curtail Federal Government spending, and funds are not requested in 1987. These funds were added to the budget by Congress in excess of the Administration's request and the program's needs. Determinations on the need for long-term epidemiological studies should be considered in the context of all other drug abuse research and should compete through the peer review process for available funds.

7. Occupational Safety and Health
(Sections 301, 304, 306, 308, 310, 311, and 327 of the Public Health Service Act; Sections 20, 21, and 22, of the Occupational Safety and Health Act of 1970; and Sections 101, 102, 103, 201, 202, and 203 of the Federal Mine Safety and Health Act of 1977)

1987 Authorization: Indefinite

Budget Authority:

1986 Appropriation	1986 Available after Sequestering		1986 Revised Estimate	1987	Increase or Decrease
			Research		
$58,923,000	$56,168,000		$56,168,000	$60,036,000	+$3,868,000
		FTE	806	806	-
			Training		
8,760,000	8,383,000		-	-	-
		FTE	-	-	-
			Total		
67,683,000	64,551,000		56,168,000 /1	60,036,000	+3,868,000
		FTE	806	806	-

/1 The 1986 revised estimate reflects a decrease of $11,515,000 in Research from the Congressional allowance: $2,911,000 as required by the Gramm-Rudman-Hollings Deficit Reduction Act, $221,000 withheld from obligations as required by Section 515 of the Treasury-Postal Services Appropriation Act of 1986, and a proposed rescission of $8,383,000.

Purpose and method of operation - The objective of this activity is to prevent work-related hazards for 104 million U.S. workers. According to the Department of Labor's Bureau of Labor Statistics (BLS) about one out of every ten workers in private industry suffers an occupational injury annually; about four out of 100 workers are disabled from these injuries; and approximately seven workers in 100,000 are killed on the job each year. The program is designed to conduct research, recommend criteria for standards; and respond to requests of workers, employers, and government agencies for health hazard evaluations in an effort to prevent premature mortality, reduce unnecessary morbidity, and improve the quality of the Nation's workplaces.

The National Institute for Occupational Safety and Health (NIOSH) is the only Federal organization with a specified mission to conduct research in industrial populations. Its right-of-entry to worksites authority permits actual workplace exposure observations essential to both experimental and epidemiologic research studies in occupational safety and health. The comprehensiveness of the research program provided through its legislative mandate--its ability to coordinate laboratory investigations, field surveys, and epidemiologic studies so that appropriate standards and controls can be recommended--make NIOSH research unique in the research community. Research is directed toward: identifying occupational safety and health problems so as to detect and define epidemiologically significant changes in the status of occupational safety and health through a workforce surveillance and health hazard evaluation program, and evaluating occupational safety and health problems and occupational hazards so as to understand their causes and to develop methods of prevention. Research is focused on the "ten leading work-related diseases and injuries, and controlling work-related injury and illness through discovering, assessing, and improving applicable engineering controls, protective equipment, work practices, and hazard-detection devices. Scientific findings and appropriate recommendations are disseminated to all organizations and individuals with the need to know to assist them in acting to reduce occupationally related health problems.

Accomplishments

Accomplishments since the establishment of NIOSH in 1972 include: completed 4,045 health hazard evaluations; completed 233 industry-wide epidemiologic investigations; completed 42 control technology assessments; recommended 123 standards to the Department of Labor to protect workers from particular occupational hazards; added 7,559 new substances to the Registry of Toxic Effects of Chemical Substances (RTECs), totaling now 80,145 chemicals and 209,172 synonyms, added 8 schools of business to the Project Minerva program, bringing the total to 29. During FY 1985, NIOSH: published a Current Intelligence Bulletin on dinitrotoluenes, a criteria document on foundries, four Alerts-electrocutions (fast food restaurants), electrocutions (cranes), excavations, and water spray fogs; completed 84 field data collection surveys for the National Occupational Health Survey of Mining; completed 49 Fatal Accident Circumstance and Epidemiology (FACE) investigations; issued 163 new respirator certifications; published a major review that identifies 850 neurotoxic chemicals and their effects; published a supplement to the NIOSH Manual of Analytic Methods, 3rd Edition (these revised methods now cover approximately 300 commonly determined toxic substances); published a new NIOSH Certified Equipment List of approved respirators; revised and published a new edition of the NIOSH Pocket Guide for Chemical Hazards; and published and distributed the booklet, The Need to Address Occupational Safety and Health in Engineering Programs:

1987 Budget Proposal

Research

Research is conducted by a core of occupational safety and health professionals operating in multi-disciplinary teams that include epidemiologists, industrial hygienists, physicians, and toxicologists. Intramural research is complemented by grants, contracts, and cooperative agreements to form an integrated program.

A. Identification of Work-Related Injuries and Illnesses through:

1. Surveillance: The Public Health Service's 1990 Prevention Objectives for the Nation include adoption of an ongoing work-related hazard illness and injury coding system and development of a surveillance capability for identification of workplace hazards and related health effects. Recent surveillance activities surveyed approximately 5,000 general industry workplaces and about 1.9 million workers and provided information on the types of industries where potential hazards are found and the occupational groups involved. These surveys also provide data on the chemical components of trade-named products. The National Occupational Hazard Survey (NOHS) and the National Occupational Exposure Survey (NOES) provide ingredient information on 100,000 trade-named products found in the workplace. These surveys also identify the industries and occupations at high risk because of exposure to toxic compounds. During FY 1985, the Institute completed the first round of the National Occupational Health Survey of Mining (NOHSM) which identified chemical exposure conditions and other hazards in the mining industry. Safety surveillance uses epidemiologic techniques, the distribution of occupational injuries by occupation, age, sex, and related demographic and causal factors to identify populations at risk. Data on traumatic injuries and fatalities are obtained from the National Electronic Injury Surveillance System (NEISS) of the Consumer Product Safety Commission which uses reported cases of occupational trauma from hospital emergency rooms. Preliminary analyses of NEISS data have led to enhanced uses of the data base for studying occupational injury trends and identification of representative cases for follow-up investigations.

2. Health Hazard Evaluations (HHE): Both the Occupational Safety and Health Act and the Federal Mine Safety and Health Act require the evaluation of the potential toxicity of materials used or found in the workplace upon receipt of written requests by employers or employee representatives. These investigations evaluate the substances, processes, and work practices found in the workplace. In response to the specific problem of occupational fatalities, the Fatal Accident Circumstance and Epidemiology (FACE) project has been developed and implemented. This project surveys injury sites and collects circumstance-specific information. Methods are being devised to work more closely with State health departments in conducting occupational health hazard evaluations.

	1985 Actual	1986 Estimate	1987 Estimate
Number of HHE's completed	553	575	580
Number of HHE's requested	582	600	605

B. Evaluation of Occupational Safety and Health Problems Through Targeted Intramural and Extramural Research - In FY 1985, NIOSH convened the National Symposium on the Prevention of the Five Leading Work-Related

Diseases and Injuries. Individuals and organizations from all sectors of the occupational safety and health community were invited, and more than 400 representatives from industry, labor, government, academia, the health professions, the insurance industry, the media, and other interested persons met for the first time to share their ideas and concerns. The objective of this symposium was to define national strategies for the prevention of diseases and injuries in the workplace. A second symposium for the last five work-related diseases and injuries is planned for FY 1987. Recommendations resulting from the symposium are now being finalized and will be used to direct NIOSH's research in these areas.

The causes of the ten leading work-related diseases and injuries are evaluated through epidemiologic and laboratory studies conducted either by NIOSH scientists, or by research grants. The ten leading causes are:

1. Occupational Lung Diseases: Occupational lung diseases, which include silicosis, asbestosis, byssinosis, coal workers' pneumoconiosis, emphysema, and chronic bronchitis, are the primary complex of occupational diseases facing the nation today. Lung cancer, which is the most frequent cause of death from malignant disease in men and the third most frequent cause in women, has been linked to occupational exposures to inhaled carcinogens. The likelihood of toxic exposure is high. Since 1940, for example, an estimated 18.8 million workers have been or are exposed to potentially hazardous concentrations of asbestos, and millions more are exposed to fibrogenic, alergenic, and carcinogenic dusts in the mining, manufacturing, chemical, and agricultural industries. NIOSH conducts research to identify etiology, substitute materials and ways of intervention. Recommendations from the symposium included research to identify etiology, substitute materials, and means of intervention, as well as the need for improved systems of surveillance.

2. Musculoskeletal Injuries: Musculoskeletal disorders rank first among health problems in frequency of occurrence and impact on quality of life. These disorders are the leading cause of disability of people in their working years, afflicting 19 million workers. The cost of musculoskeletal disorders, based on lost earnings and worker compensation payments, exceeds that of any single health disorder. Back problems alone cost American industry an estimated $14-17 billion each year in workers' compensation costs. The objectives of the program include identification of high risk occupations, development of medical diagnostic criteria, evaluation of work tasks with safety risks, evaluation of detrimental lifestyle behavior, design changes in work methods and tools, and effective information dissemination procedures.

3. Occupational Cancers: Cancer is the second leading cause of death in the United States, killing approximately 430,000 people annually. A high proportion of all cancers are caused by environmental factors, which can be identified or controlled. It has been estimated by leading international epidemiologists that 4 to 20 percent of these cancers (17,200 - 86,000 annually) are caused by occupational

exposures. Studies to identify cancer-causing industrial chemicals and other factors are being conducted. Activities include detailed industrial hygiene surveys, industrywide epidemiologic hygiene studies, and retrospective cohort mortality studies to assess the cancer risk among workers exposed to various agents. Other approaches used to identify cancer clusters include case-control, proportionate mortality, and sample cohort studies.

4. Severe Occupational Traumatic Injuries: Each year an estimated 10,000,000 workers are injured on the job of which 10,000 injuries are fatal and 3 million severe. The economic impact of such workplace accidents is very large: overall in 1984 workplace injuries equated to over $33 billion or about 1 percent of the 1984 gross national product. Social security disability figures for 1984 indicate the cost of workers' compensation premiums alone was approximately $16.6 billion annually. Traumatic injuries to the muscle, skeleton and surrounding tissues are extensive with estimates of 21,000 amputations, 400,000 fractures, 2,250,000 lacerations and 900,000 eye injuries annually. Sprains and strains are the most prevalent injury with 50 percent being back related. Back injuries alone account for 32 percent of workers' compensation claims and 42 percent of compensation costs for a total annual cost of $15 billion. Prevention strategies for these injuries and fatalities are based upon a multidisciplinary scientific approach utilizing state-of-the-art engineering research; the application of epidemiologic principals to identify high risk occupations, industries, and practices; publication of research findings; and strategic dissemination of practical prevention guidelines based upon fatality investigations.

5. Occupationally Related Cardiovascular Diseases: Cardiovascular diseases (CVD) including ischemic heart, hypertensive disease, other forms of heart disease, and cerebrovascular disease, are responsible for more deaths in the United States each year than any other category of disease. In 1980, CVD claimed over 960,000 lives. Although the rates of death from cardiovascular diseases have declined gradually over the last decade, coronary atherosclerosis and acute myocardial infarction remain the leading causes of death in the United States. Because heart diseases still are so prevalent, identifying and preventing occupational factors that result in even a small increase in the relative risk of cardiovascular disease would involve large numbers of persons. Thus, preventing any occupational contribution to this problem would be an important public health measure. Some of the prevention measures recommended at the recent symposium included: (1) programs to reduce personal risk factors for cardiovascular disease among workers with significant exposures to cardiotoxins should be initiated concomitantly with efforts to reduce work-related risk factors; (2) a number of substances and physical agents require better medical, epidemiological, and/or toxicological study of their effects on the cardiovascular system; (3) a parallel effort should be made to improve the methods for toxicological assessment of possible cardiotoxic substances; and (4) efforts should be made to increase the availability of health promotion programs in the workplace.

6. Disorders of Reproduction: Recent research data have highlighted the fact that the occupational setting can be the source of reproductive hazards as well as of the more commonly acknowledged effects such as lung dysfunction, cancer, and dermatitis. Research in this area includes information on male sterility in dibromochloropropane workers, impotence in workers exposed to a neurotoxin, increased birth defects among children born to women pharmaceutical workers, concern about adverse effects from glycol ethers on the reproductive system of both males and females, and excessive spontaneous abortions among medical laboratory and office workers, and hospital and dental personnel exposed to anesthetic gases. Studies have shown the need for better means to identify and evaluate hazardous chemicals and populations at risk and to determine whether an occupational cluster of reproductive disorders is actually a result of occupation. Studies include laboratory methods aimed at identifying teratogens and mutagens that may be used in the workplace; surveillance studies that use record systems to identify possible associations between parental employment and reproductive loss, and epidemiologic studies of high-risk groups of workers. Also, a committee has been established to review the area of occupationally-caused disorders of reproduction and develop a national strategy of prevention.

7. Neurotoxic Disorders: Industrial chemicals and neurotoxins may produce effects ranging from mild to severe and include motor changes (gait disorders, incoordination, and tremors), sensory changes (impaired vision, hearing, and touch), and cognitive changes (loss of alertness, lapses in judgment, and personality changes). More than one-fourth of the 575 major industrial chemicals identified by the American Conference of Governmental Industrial Hygienists as in need of Threshold Limit Values (TLVs) have been identified as neurotoxic at low exposure levels. Research efforts include identification and evaluation of chemical hazards as a means of determining safe exposure limits for substitute materials to reduce occupational exposures.

8. Noise-Induced Loss of Hearing: In the U.S., approximately 5.1 million workers are exposed to hazardous levels of continuous noise and approximately 3 million others are exposed to potentially hazardous levels of impulse noise. Impulse noise such as that from hammering and collision may produce hearing loss at a rate different from continuous noise. NIOSH's continuing studies which include research on the measurement and effects of noise as well as the relative hazards from different types of noise. Methods are being developed to test the effectiveness of hearing protectors, define rates of hearing deficiencies in different populations, and develop programs to foster hearing conservation.

9. Dermatologic Conditions: Compensable occupational skin diseases and disorders represent 40% of all reported job-related illnesses. It is estimated that 80% of all dermatologic problems experienced by workers is chemical in origin and involves exposure to primary irritant chemicals. The Institute's priorities in this area are to develop dermatology competence and identify worker groups and the extent of dermatologic disease produced by chronic physical trauma to the skin.

10. Psychologic Disorders: Stress is linked with increased risk of cardiovascular disease, digestive disorders, and nervous disturbances. Research conducted on machine-paced work and computerized office work systems has shown emotional disturbances and physical health complaints which have been related to perceptions of heavy workload and pressure, loss of control over job tasks, poor physical/ergonomic conditions, and fears of job loss. The annual productivity losses, absenteeism, and company health care expenses due to stress-related mental illness have been estimated at $50 to $75 billion. Studies are underway to establish a scientific base for defining and evaluating working conditions that produce psychologic stress and to develop strategies for controlling stress-related disorders.

Research Grants - The large number of interacting factors causing, or having potential to cause occupational disease, injury, or premature death suggests the need for a strong program of research to identify and evaluate these problems so solutions can be developed and implemented to control them. The research grants program draws upon the resources of a large range of non-profit and for-profit organizations. Universities, colleges, research institutions and other public and private organizations including State and local governments and small, minority businesses are eligible to apply. Besides the traditional project grants, a small grants activity is now a standard part of the grants program and is designed to provide support primarily for predoctoral graduate students and postdoctoral researchers. To create a pool of highly qualified investigators with experience and skills in occupational safety and health for future roles in related areas of research, a special emphasis research career grant was also added to the program to encourage qualified individuals in the early stages of their post-graduate medical and scientific careers to develop research interests and skills in the area of occupational safety and health. The extramural research programs will emphasize the ten leading work-related diseases and injuries, as well as, research on control technology and respirators.

Research Grants

	1985 Actual		1986 Estimate		1987 Estimate	
	No.	Amount	No.	Amount	No.	Amount
New	26	$2,083,302	25	$1,594,862	40	$2,956,400
Non-competing continuations	61	4,417,698	53	4,626,138	40	3,544,600
Total	87	$6,501,000	78	$6,221,000	80	$6,501,000

C. Control of Work-related Injury and Illness through developing and improving measures to reduce occupational hazards including use of engineering controls, personal protective equipment, work practices, and hazard-detection devices.

Control Technology - Following identification and evaluation of workplace conditions causing or having potential to cause occupational disease or injury, measures can be developed to eliminate these conditions. These measures consist of proper workplace design and work practices, usually in combination. NIOSH conducts control technology assessments, research, and demonstrations, the results of which are directed to industry, labor, health professionals, educational institutions, small businesses, insurance loss control programs, and Federal and State regulatory health and safety programs. Major areas studied include chemical processing technology, solid materials handling, manufacturing processes such as tire building and electroplating, service industries such as dry cleaning and asbestos removal, hazardous materials such as silica flour and ethylene oxide, and control techniques such as air recirculation and push-pull local exhaust ventilation. In situations where work practices are important, behavior, motivation, and ergonomic factors are also studied as they are critical to the success of control measures.

Instrument and Methods Development - Monitoring the workplace environment is fundamental to conducting a preventive health program in the workplace. Research is conducted to develop and evaluate new air sampling and analytical methods, biological monitoring methods, and direct reading instruments for use in measuring and controlling potential chemical and physical hazards in the workplace. Studies are performed to provide performance criteria for aerosol sampling, which is important for determining risk factors in mining, textiles and primary metals industries. Monitoring devices for use inside respirator masks and in various workplace environments are developed and evaluated.

Respirators - In recent years, use of respiratory protection in the workplace has increased significantly, due both to increased knowledge and public awareness of the existence of toxic agents in workplace environments and increased emphasis by Federal and State regulatory agencies on use of respirators to obtain reductions in workplace exposures to toxic agents. This increase had a decided impact on the NIOSH certification program. Since 1980, the number of respirator certifications issued more than doubled (from 529 to 1258). This increase has been managed by streamlining administrative procedures and installing computer technology to control laboratory procedures.

As respirator use has increased, so has the need for improvement in the quantity, quality, and types or respirators available. NIOSH is continuing research efforts in this area, and is conducting studies to improve performance standards and test procedures that are used to evaluate the performance of respirators. Also, in-plant surveys of manufacturers' facilities to evaluate respirator performance and reliability are being conducted.

4. Disseminate scientific findings and recommendations to organizations and individuals able to use this information to reduce occupational disease and injury.

Research findings and recommendations are disseminated through various channels:

Recommendations for regulatory action and other policy statements are transmitted to the Occupational Safety and Health Agency and the Mine Safety and Health Agency and to other regulatory agencies in response to their regulatory activities. NIOSH policy statements are prepared in various forms including criteria documents, current intelligence bulletins, alerts, and regulatory responses. To date 117 criteria documents have been submitted to the Department of Labor (DOL) recommending measures for improving workplace safety and health. In addition, 44 current intelligence bulletins have been transmitted to DOL to keep them informed of the latest research findings pertinent to hazards found in the workplace.

Recommendations are provided directly to union and industry representatives and members so that they can take independent action to reduce occupational disease and injury. In circumstances where immediate action is required to protect workers, such as (electrical hazard in fast food restaurants), this direct communication is especially important.

Findings are published as NIOSH research reports, technical guidelines, and fact sheets and disseminated to Federal, State, and other research organizations involved in occupational safety and health, trade publications, industry and labor representatives, and individuals in response to their requests for information.

Findings are published as articles and abstracts in scientific journals, articles in the Morbidity and Mortality Weekly Report (MMWR), as proceedings, books and book chapters for dissemination to the scientific community and the general public. In Fiscal Year 1985, NIOSH scientists produced 259 peer-reviewed publications presenting their findings.

Findings are disseminated through educational efforts, conferences, and cooperative efforts with other government, industry, labor, and university representatives. As mentioned earlier, in May 1985, NIOSH held a national symposium including members from all interests in occupational safety and health. The objective of the symposium was to define national strategies for the prevention of the first five of the ten leading work-related diseases and injuries. The symposium, which was held FY 1985, and the publications and joint activities being developed subsequent to the symposium will further our efforts to disseminate information on these diseases and injuries and help put this information in use reducing these problems. The second symposium to be held in FY 1987 and the resultant publications and activities will continue to further our dissemination efforts in these diseases and injuries.

Training

The development of Occupational Safety and Health Educational Resource Centers has demonstrated the effectiveness of providing both full time and continuing education--training of occupational safety and health professionals, specialists, and technicians as well as becoming a resource to management and labor for the region in which they are located.

The Educational Resource Centers (ERC) have been federally funded for the past nine years. The decrease in the training activity represents the phasing out of this program with a shift toward private sector financing in FY 1986.

A 1986 rescission of funds appropriated for the ERC program is proposed as part of the President's overall budget reform plan to curtail Federal Government spending, and funds are not requested in 1987. The Educational Resource Centers (ERC) have been federally funded for the past eight years. The proposed rescission represents the successful completion of the Federal ERC program of expanding university programs to meet increased student, business, and public health interest in the occupational health field, with a proposed shift toward State and private sector financing. The principal users of those individuals trained (industry and State governments) should now increase their financial support to maintain these centers. Nine of the existing 15 university-based ERC's have had Federal development support for eight years. They should now be able to sustain and continue their academic and continuing education training programs.

Training Grants

	1985 Actual		1986 Estimate		1987 Estimate	
	No.	Amount	No.	Amount	No.	Amount
New	6	$ 415,000	-	$ -	-	$
Continuations	32	8,344,845	-	-	-	
(Educational Resource Centers)	15	(7,367,913)	(-)	(-)	(-)	(-)
TOTAL	38	$8,760,000	-	$ -	-	--

Impact Data

Intramural Research	FY 85 Actual	FY 86 Estimate	FY 87 Estimate
Identification:			
Surveillance	$ 6,535,400	$ 6,518,000	$ 6,974,000
Health Hazard Evaluation/Technical Assistance	8,738,700	8,843,000	9,462,000

Intramural Research: (Cont'd)	FY 85 Actual	FY 86 Estimate	FY 87 Estimate
Targeted Research:	14,389,900	14,615,000	15,680,000
Occupational Lung Diseases	(5,081,800)	(5,167,000)	(5,528,000)
Musculoskeletel Injuries	(1,205,500)	(1,217,000)	(1,302,000)
Occupational Cancers	(3,352,000)	(3,422,000)	(3,662,000)
Severe Occupational Traumatic Injuries	(698,600)	(689,000)	(737,000)
Occupationally Related Cardiovascular Dis.	(336,000)	(309,000)	(331,000)
Disorders of Reproduction	(1,685,600)	(1,733,000)	(1,854,000)
Neurotoxic Disorders	(787,400)	(829,000)	(887,000)
Noise-Induced Loss of Hearing	(349,000)	(362,000)	(387,000)
Dermatologic Conditions	(275,300)	(254,000)	(315,000)
Psychologic Disorders	(618,700)	(633,000)	(677,000)
Control and Personal Protective Equipment	7,975,700	8,235,000	8,811,000
Dissemination	6,051,300	6,593,000	7,015,000
Total	$43,691,000	$44,804,000	$47,942,000
Extramural Research:			
Identification:			
Surveillance	$ 1,140,400	$ 724,000	$ 775,000
Health Hazard Evaluation/Technical Assistance	370,000	346,000	370,000
Targeted Research:	7,321,400	7,384,000	7,892,000
Occupational Lung Diseases	(1,894,900)	(1,907,000)	(2,061,000)
Musculoskeletal Injuries	(879,700)	(822,000)	(851,000)
Occupational Cancers	(1,052,000)	(1,033,000)	(1,091,000)
Severe Occupational Traumatic Injuries	(402,200)	(430,000)	(460,000)
Occupationally Related Cardiovascular Dis	(160,800)	(305,000)	(326,000)
Disorders of Reproduction	(784,400)	(822,000)	(915,000)
Neurotoxic Disorders	(1,067,400)	(815,000)	(851,000)
Noise-Induced Loss of Hearing	(473,500)	(549,000)	(587,000)
Dermatologic Conditions	(248,200)	(328,000)	(351,000)
Psychologic Disorders	(358,300)	(373,000)	(399,000)
Control and Personal Protective Equipment	2,488,400	2,053,000	2,197,000
Dissemination	1,565,800	858,000	860,000
Total	$12,886,000/1	$11,365,000/2	$12,094,000/1

/1 Includes $6,501,000 in research grants
/2 Includes $6,221,000 in research grants

---

8. Epidemic services
   (Sections 301, 304, 306, 307, 308, 310, 311, 322, 325, 327, 352, 353, and 361 thru 369 of the Public Health Service Act)

1987 Authorization:

Budget Authority:

	1986 Appropriation	1986 Available after Sequestering	1987	Increase or Decrease
Program Operations	$51,766,000	$49,561,000 /1	$53,597,000	+$4,036,000
User Fees	-466,000	-447,000	-466,000	-19,000
Total	51,300,000	49,114,000	53,131,000	+4,017,000
FTE		863	863	-

/1 The 1986 available after sequestering reflects a decrease of $2,205,000 from the Congressional allowance: $2,226,000 as required by the Gramm-Rudman-Hollings Deficit Reduction Act, and $19,000 withheld from obligations as required by Section 515 of the Treasury-Postal Services Appropriation Act of 1986. This reduction is partially offset by an increase of $40,000 for unobligated balance carried forward.

Purpose and Method of Operation

The early recognition of adverse health conditions and the rapid application of prevention and control measures are fundamental to CDC's contribution to protecting the health of the American people. Bringing epidemic situations to rapid and successful conclusions prevents costly morbidity and mortality. The cost effectiveness of these activities has been well documented just in terms of curative costs averted. The activities of surveillance and epidemiology support this CDC-wide response capability.

The objectives of the epidemic services activity are to: (1) provide for the prevention and control of epidemics; (2) maintain surveillance systems, analyze data, and respond to public health problems when indicated; (3) develop public health epidemiologists; and (4) carry out the quarantine program as required by regulations. CDC must also maintain competence in many diseases that seldom occur, such as plague, Lassa Fever, etc., and provide laboratory capabilities to support disease investigations.

The epidemic services activities are an important part of this Nation's approach to protecting its civilian population from epidemics and from deliberate or accidental misuse of chemicals and biological agents. These programs are carried out by maintaining surveillance systems, epidemic investigators, and laboratory capabilities for identifying specimens and data, potential problems, investigating, identifying, collecting, analyzing, and recommending appropriate actions to protect the health and lives of the American people.

In addition, and as part of the Centers' efforts to implement the 1990 national prevention objectives under this activity, CDC conducts a program of scientific inquiry and research to solve practical public health problems and supports selected programs to assist States, health organizations, and others in the health field to achieve the prevention goals in two priority areas: pregnancy and infant health; and reproductive health.

Accomplishments

An outbreak of over 16,000 cases of antimicrobial-resistant S. typhimurium infections were investigated in Illinois. The investigation showed that: the source was pasteurized milk from one dairy; an estimated 150,000-300,000 cases actually occurred; taking antimicrobials predisposed persons to develop symptomatic infections; and outbreaks of the same rare strain had been caused by milk from the same dairy during the previous year.

Investigated an outbreak of epidemic listeriosis in Southern California, causing at least 28 deaths or stillbirths. Mexican-style soft cheese was implicated as the vehicle. Pregnant Hispanic women were at particular risk. Raw milk was the presumed source of contamination.

In collaboration with the Minnesota State Department of Health, identified a new illness of thyrotoxicosis due to ingestion of beef trimmings contaminated with beef thyroid gland. This, in turn, led to an Iowa beef products recall of trimmings produced by a Minnesota plant and to the United States Department of Agriculture, Food Safety and Inspection Service, declaring, August 29, 1985, that neck trim is "inedible" in the United States.

CDC conducted 92 major epidemic investigations during 1985. Three of these involved more than one State and eight were international investigations. Two large notable investigations were related to an outbreak of Salmonella in Illinois and of Listeriosis in California. A major investigation of Parkinsonism related to "designer drugs" is continuing.

Epidemiologists assigned to State and local health departments conducted 622 investigations, 69 of which included 100 or greater individuals. They also conducted 60 separate projects designed to develop new information related to the 1990 objectives.

Weekly telephone reporting of morbidity data for the MMWR has been replaced by computer to computer communication over a telecommunications network in eight States. This increases rapidity of reporting and analyses, as well as the sophistication of analyses.

A strategic plan for surveillance has been developed. A Surveillance Coordination Group has been formed representing all CDC components, and they have drafted a surveillance policy statement.

A computer-based surveillance system is being pilot tested with 15 States to more rapidly and thoroughly evaluate reports of disease.

The 1980 National Natality Survey was used to estimate that 25% of low birth weight (LBW) in the U.S. was attributable to smoking.

In collaboration with the Missouri health department, it was found for the first time that regardless of maternal risk status, smoking increases the risk of LBW by 2-fold; for very high-risk groups, infants of smoking mothers have a 1-in-7 risk of being LBW.

1987 Budget Proposal

In fiscal year 1987, $53,597,000 is being requested to improve the epidemic services required to protect the health of the American people. This reflects $53,131,000 in new budget authority and $466,000 in estimated user fee collections for providing reference diagnostic reagents to commercial manufacturers and providing proficiency testing services to private clinical laboratories. Activities in 1987 will include:

Epidemic Intelligence Service - Since 1951, CDC has recruited health professionals for two-year assignments with the Epidemic Intelligence Service (EIS). EIS Officers are trained and assigned to work in a variety of programs at CDC and State and local health departments. EIS Officers investigate outbreaks of disease and other preventable conditions, conduct health hazard evaluations in the work place, and develop surveillance systems in support of control efforts. The Officers also provide staff support for emergency disease prevention and control activities related to the 1990 objectives. Nearly 1300 health professionals have served as EIS Officers with about one-third continuing careers in public health at various levels of government, one-third in universities, and one-third in the private sector. These Officers have completed many thousands of epidemic investigations throughout the country and the world to the benefit of the American people.

Surveillance - Disease surveillance activities at CDC represent the close cooperation needed between Federal, State and local governments and the private medical community to effectively provide public health services. Reports of morbidity and mortality originate with the private physician or hospital. Individual cases of morbidity are reported to local health departments and in turn to State Health Departments and the CDC. CDC collects these reports weekly and disseminates tabular information in the publication Morbidity and Mortality Weekly Report (MMWR), along with narrative reports of disease outbreaks, trends in adverse health conditions, and advisories on therapeutic, immunization, and prevention practices. While this reporting system has been in effect since 1918, the number and specific diseases reported are continually reviewed and changed as appropriate. AIDS has most recently been added to this reporting system. This comprehensive reporting system is supplemented by other surveillance activities such as the sentinal hospital reporting of nosocomial infections.

Foreign Quarantine - The regulatory responsibilities of the Quarantine Program are: preventing importation and spread of communicable diseases; developing and disseminating health information to the traveling public; conducting medical examinations of aliens in accordance with the Immigration and Nationality Act; controlling importation of animals, etiologic agents, and vectors of public health importance; performing inspections of vessels for plague control; and issuing Deratting/Deratting Exemption Certificates.

In FY 1987, CDC will fund activities to meet the program objectives which are: overseeing the performance of medical examinations of aliens to detect excludable health conditions overseas and at U.S. ports of entry; providing public health screening at ports of entry; enforcing entry requirements to prevent and control the introduction and spread of communicable diseases transmitted to humans from animals, etiologic agents, and vectors; assuring timely distribution of investigational drugs and immunobiologics to patients in order to minimize morbidity and mortality; collecting and disseminating worldwide health data; and providing travelers with essential health information.

Legionellosis - Legionellosis is an acute infection of humans caused by bacteria in the genus Legionella. The disease may be present as pneumonia or as a self-limited febrile illness, in either epidemic or sporadic form. An estimated 52,000 cases occur annually in the U.S. The disease is probably underdiagnosed due to lack of readily-available diagnostic methods. The case fatality ratio for the pneumonic form is 14 percent or 7,200 deaths per year. The annual cost for legionellosis in the U.S. is estimated at $34 million. Water appears to be the natural habitat and reservoir of Legionella, but factors in disease transmission from contaminated water are not well understood. Eradication of Legionella from water sources is difficult, expensive, and has attendant health risks. At least a dozen new Legionella-like organisms are being studied. CDC surveillance activities indicate that legionellosis has occurred in almost all of the 50 States and in at least 15 foreign countries.

Resources will be used to: enhance prompt diagnosis and treatment of legionellosis; develop a surveillance program sufficiently sensitive to estimate actual incidence and to detect changes or trends; determine principal means of transmission of epidemic and sporadic legionellosis; and develop control strategies to reduce by at least 90 percent the Legionella species in potable water systems, cooling towers, and respiratory-therapy equipment and humidifiers associated with occurrence of disease.

Malaria - Worldwide, malaria is one of the most common infectious diseases. Millions of cases and substantial mortality occur annually in the tropical areas of Africa, Asia, and the Americas. More than 1,000 imported cases are reported each year in the U.S., and many U.S. travelers are exposed to potentially fatal malaria. Interruption of malaria transmission in most tropical areas is unlikely in the near future. However, control of the principal adverse consequences of malaria-excess deaths in children and pregnant women, chronic anemia and under-nutrition, and diminished productivity of the work force-is a realistic goal. Malarial transmission and mortality can be reduced by an attack on the mosquito vector and by drug therapy of infections. Risk in U.S. travelers can be reduced by the prophylactic use of effective antimalarial drugs. Documentation of geographic variation in drug sensitivity is required for travel recommendations.

During FY 1987 CDC will continue to: develop denominator-based malaria rates for U.S. travelers to individual countries or areas to identify high-risk travel; monitor drug sensitivity in collaboration with WHO and national governments for chemoprophylaxis recommendations; collaborate with Peace Corps and State Department medical groups to formulate and implement malaria prophylaxis and therapy guidelines for their personnel; and assess chloroquine sensitivity in Central and West Africa to define epidemiology of resistance in Africa.

Dengue fever - Dengue fever is an acute flaviviral disease transmitted by mosquitoes. In terms of morbidity, dengue is the most important vector-borne viral disease of man. Repeated large epidemics, each involving up to several million people occur in tropical areas of Asia, Africa, and the Americas and may extend into temperate areas where Aedes aegypti mosquitoes occur. Epidemics in the Caribbean area have occurred at increasing frequency in the past 20 years. The largest outbreak in the Americas was due to dengue 1 virus; it began in 1977 and reached south Texas in 1980. In Puerto Rico alone, the 1977 outbreak caused 12,000 reported cases and resulted in an estimated economic loss of $11 million. Fifty to 150 imported dengue cases occur annually in the U.S., including states infested with Ae. aegypti, underscoring the threat of secondary transmission. Since 1981, all 4 dengue serotypes are endemic in the Caribbean.

During 1987, efforts to reduce morbidity include the: development of an emergency vector control strategy capable of preventing the spread of newly-introduced dengue serotype; development and implementation of strategies to reduce vector mosquito populations below the level required for disease transmission in three demonstration areas within Puerto Rico; and dissemination of newly developed diagnostic tests and control strategies to health agencies in the Western Hemisphere.

Plague - Bubonic plague is an acute infection of humans caused by the bacteria Yersinia pestis. Plague is firmly established among wild rodents and their fleas in 15 western states. Human cases since 1975 have averaged about 18 per year, with a case fatality rate of 18 percent. In FY 1983, 40 cases were reported, a new high. Ninety percent of the cases occur in northern New Mexico and Arizona. Secondary plague pneumonia has occurred in 20 percent of 165 cases since 1975 and primary plague pneumonia in 4 percent. Both forms are transmissible from person-to-person by expelled droplets. Discovery in 1982 and 1983 of plague among mingled urban rat and wild rodent populations in Los Angeles demonstrates that epidemic plague remains a threat.

Steps necessary to prevent occurrences of plague include the: development of standardized procedures for rapid and specific diagnosis and the dissemination of these procedures to State and local public health laboratories; development of a surveillance system sufficiently sensitive to detect and control focal plague activity; continued study of biological, environmental, and human risk factors associated with plague in targeted areas; and collaboration with State and local agencies, Indian Health Service, and U.S. Fish and Wildlife agencies to expand existing surveillance programs.

Infant Mortality - Included in this request is $1,750,000 to fund two new components of the PHS infant mortality initiative. The recent interest in the U.S. infant mortality problem has centered around concerns that the rate of infant mortality decline has slowed down, concerns about the disparity in the infant mortality rates between blacks and whites, and about the lack of progress in reducing the incidence of low-birth weight (LBW). Significant costs to society are associated with low birthweight infants. Approximately 6% of all live births account for neonatal intensive care costing $1.7 billion annually. The average cost per admission for an infant weighing less than 1500 grams is approximately $15,000. This is but a fraction of the total economic costs resulting from this condition when the permanent developmental and physical impairments are considered.

Low birthweight among infants is a major factor associated with neonatal and infant mortality. Moreover, low birthweight is associated with maternal health behaviors during pregnancy, such as use of cigarettes, alcohol misuse, and poor nutritional practices. For instance, over 900,000 children are born each year to women who smoke, a practice that doubles the risk of LBW and increases the risk of stillbirth or neonatal death by up to 100%. Cessation of health risk behaviors can have a positive effect on birth outcome. To help States better address this health issue, a comprehensive mechanism is needed which can: identify those populations at highest risk; enable States to target their intervention efforts; and provide resources for evaluating progress towards the 1990 objectives related to low birthweight.

Two mechanisms exist which, in combination, can address the problem: the Pregnancy Nutrition Surveillance System (PNSS) and Behavioral Risk Factor Surveillance System (BRFSS). However, they cannot adequately serve this expanded purpose without substantial enhancement. This initiative would accomplish the development and refinement of the systems to address health risk factors in pregnancy. This will significantly increase State capacity to monitor health-related behaviors associated with poor pregnancy outcome and to use the information to direct intervention efforts more precisely and efficiently to those areas and populations in greatest need. The outcome will be a reduction of premature death and preventable morbidity in our most vulnerable population--infants of low income parents.

During the past several years, several forces have converged to demonstrate the need for State health department capacity to use the epidemiologic approach to address problems of maternal and child health. State interest has grown as the problems of low birthweight and infant mortality have become more severe. CDC will develop, over the next 3-5 years, a program to build the epidemiologic capability of State Maternal and Child Health Divisions.

Four out of the top ten causes of premature life lost from 0 to 65 relate to infant mortality. In addition, much life long morbidity, such as cerebral palsy and mental retardation, have their antecedents in the prenatal, perinatal, and infant period. Several analyses have suggested that substantial proportions of this mortality and morbidity are preventable. A substantial reduction in morbidity/mortality, therefore, and a concomitant improvement in the quality of life throughout the Nation can be expected as States gain the information to direct program priorities and intervention efforts more precisely and efficiently to those in greatest need.

Assuring all infants a healthy start in life and enhancing the health of their mothers are among the highest priorities in preventing disease and promoting health. The relatively small investment required to improve surveillance mechanisms for targeting health services to vulnerable populations can pay enormous dividends in reducing risks of illness or even death among newborns.

---

9. Building and Facilities
(Section 321(a) of the Public Health Service Act)

1987 Authorization: Indefinite

Budget Authority:

1986 Appropriation	1986 Available after Sequestering	1986 Revised Estimate	1987	Increase or Decrease
$ 3,797,000	$29,429,000	$27,527,000 /1	$1,810,000	-$25,717,000
	FTE	-	-	-

/1 The 1986 revised estimate reflects an increase of $23,730,000 from the Congressional allowance: $25,795,000 increase for unobligated balance carried forward from the prior year, partially offset by a decrease of $163,000 as required by the Gramm-Rudman-Hollings Deficit Reduction Act, and a proposed rescission of $1,902,000.

Purpose and Method of Operation

The CDC's Facility Planning Board has the responsibility to: (1) assess the adequacy of CDC facilities and equipment to do its job and to assure that all facilities, particularly laboratories, are safe for both workers and the community; (2) protect the facility investment of the Centers for Disease Control by preventing deterioration and by upgrading, where necessary, to insure that facilities meet current required standards; and (3) meet the Centers' responsibility to reduce or conserve the energy necessary to operate the Centers' facilities and equipment.

To meet these goals, the Facility Planning Board continuously monitors the need for repair and improvement of the Centers' facilities. Priority rankings are assigned to each required project to ensure the accomplishment of those projects which are mandatory to protect the facility investment of the Centers and ensure that quality facilities are available to the programs of the Centers. The board also determines the need for and schedules major renovations, construction, and other facility and equipment projects.

Accomplishments

The construction contract for CDC's virology laboratory building was awarded on October 28, 1985.

1987 Budget Proposal

The request of $1,810,000 is for general repair and improvement projects which are required to prevent obsolescence of CDCs' facilities and equipment and to provide a safe working environment. Projects include such items as electrical modification, repair to walls, resetting copings, replacing air conditioning units, interior repair and painting, roof replacements, street repairs, laboratory improvements, and alterations to remove architectural barriers.

Other larger projects include the replacement of old or obsolete laboratories and offices to provide safe and healthy facilities for employees and to protect the environment.

---

10. Program Management
(Title III, XIX, and Section 1102 of the Public Health Service Act, the Federal Mine Safety and Health Act of 1977, and the Occupational Safety and Health Act of 1970)

1987 Authorization: Indefinite

Budget Authority:

	1986 Appropriation	1986 Available after Sequestering	1987	Increase or Decrease
	$3,096,000	$2,959,000 /1	$3,096,000	+$137,000
FTE		68	68	-

/1 The 1986 available after sequestering reflects a decrease of $137,000 from the Congressional allowance: $133,000 as required by the Gramm-Rudman-Hollings Deficit Reduction Act, and $4,000 withheld from obligations as required by Section 515 of the Treasury-Postal Services Appropriation Act, 1986.

Purpose and Method of Operation

Program management activity supports the overall direction and management to the Centers for Disease Control. This includes management policy and coordination, science policy and review, equal opportunity, legislative programs, and international cooperation. In addition to the overall administrative direction provided in these areas, the Office of the Director provides leadership activities for the Agency to assure the delivery of preventive health services to the Nation to reduce morbidity and mortality, and to improve the quality of life of its citizens.

Accomplishments

A long range Master Facilities Plan, which details CDC's facility requirements in the Atlanta area for the next ten years was completed.

Completed the combination and restructuring of information management within CDC to improve the management of information within CDC, and between CDC and State and local health agencies.

1987 Budget Proposal

The missions assigned the Centers for Disease Control are those requiring the skills of many differing disciplines and the utilization of valuable resources. The specific objective of this activity is to coordinate these disciplines and resources in a manner that focuses on both the missions of the CDC and responsible stewardship of the resources appropriated for those missions.

Effective and efficient management is provided to all the Centers, Institute, Offices, and staff elements of the Centers for Disease Control.

Other goals are to:

- Assure there is an effective and coordinated prevention approach throughout the country.
- Meet the 1990 Prevention Objectives for the Nation.
- Maintain a focal point to provide national leadership in Prevention and Occupational Safety and Health.
- Ensure that the programs of the agency are efficiently managed and internally coordinated.
- Maintain liaison within and outside the Federal Government in matters relating to disease prevention, occupational safety and health, and environmental health.

Preventive Health and Health Services
Block Grant

	FY 1985 Actual	FY 1986 Estimate	FY 1987 Estimate
Alabama	$1,504,730	$1,471,710	$1,504,730
Alaska	326,890	319,562	326,890
American Samoa	50,426	49,285	50,426
Arizona	1,089,835	1,065,886	1,089,835
Arkansas	844,454	825,959	844,454
California	6,320,373	6,184,228	6,320,373
Colorado	1,153,056	1,127,722	1,153,056
Connecticut	1,379,453	1,349,024	1,379,453
Delaware	173,300	169,548	173,300
District of Columbia	743,890	727,120	743,890
Florida	2,722,585	2,663,780	2,722,585
Georgia	2,894,030	2,829,823	2,894,030
Guam	210,572	205,799	210,572
Hawaii	743,827	727,172	743,827
Idaho	346,443	338,858	346,443
Illinois	2,209,214	2,162,718	2,209,214
Indiana	1,586,101	1,551,779	1,586,101
Iowa	1,047,495	1,024,581	1,047,495
Kansas	890,353	870,837	890,353
Kentucky	1,270,572	1,242,821	1,270,572
Louisiana	2,779,436	2,717,409	2,779,436
Maine	853,644	834,536	853,644
Maryland	1,777,482	1,738,346	1,777,482
Massachusetts	2,582,426	2,525,431	2,582,426
Michigan	3,757,928	3,675,306	3,757,928
Minnesota	2,403,615	2,350,129	2,403,615
Mississippi	1,385,659	1,354,884	1,385,659
Missouri	2,368,008	2,315,626	2,368,008
Montana	632,187	618,020	632,187
Nebraska	1,594,861	1,558,977	1,594,861
Nevada	348,687	341,000	348,687
New Hampshire	1,365,676	1,334,802	1,365,676
New Jersey	2,735,859	2,675,925	2,735,859
New Mexico	1,336,564	1,306,485	1,336,564
New York	6,540,843	6,397,537	6,540,843
North Carolina	2,574,170	2,517,412	2,574,170
North Dakota	243,687	238,347	243,687
North Marianna Island	37,790	36,932	37,790

Ohio	4,311,614	4,216,879	4,311,614
Oklahoma	884,352	865,203	884,352
Oregon	669,502	655,124	669,502
Pennsylvania	4,543,342	4,443,686	4,543,342
Puerto Rico	1,484,615	1,451,810	1,484,615
Rhode Island	451,828	441,836	451,828
South Carolina	1,154,336	1,129,052	1,154,336
South Dakota	220,231	215,441	220,231
Tennessee	1,525,908	1,492,648	1,525,908
Texas	3,731,712	3,651,416	3,731,712
Trust Territory (excl. NMI)	105,404	103,037	105,404
Utah	905,016	884,851	905,016
Vermont	259,151	253,409	259,151
Virginia	1,907,873	1,866,151	1,907,873
Virgin Islands	166,727	162,952	166,727
Washington	921,769	902,149	921,769
West Virginia	859,607	840,650	859,607
Wisconsin	1,854,342	1,813,621	1,854,342
Wyoming	216,550	211,768	216,550
TOTAL	89,000,000	87,047,000	89,000,000

CENTERS FOR DISEASE CONTROL

Estimates for Consulting Services

Account Title	Type /1	Source of Funds /2	Obligations		
			1985	1986	1987
Evaluation:					
Disease Control	C	A	$227,082	$721,000	$721,000
Subtotal, evaluation			227,082	721,000	721,000
Non-Evaluation:					
Disease Control	C	A	-	328,000	328,000
Disease Control	P	A	110,954	890,000	890,000
Disease Control	A	A	52,637	104,000	104,000
Subtotal, non-evaluation			163,591	1,322,000	1,322,000
Total, consulting services			390,673	2,043,000	2,043,000

TOTALS:	1985	1986	1987
Contractual Services	227,082	1,049,000	1,049,000
Personnel appointments	110,954	890,000	890,000
Advisory committee expenses	52,637	104,000	104,000
Total, consulting services	390,673	2,043,000	2,043,000

/1 C for contractual services, P for personnel appointments, or A for advisory committee obligations.

/2 A for appropriated funds or N for non-appropriated funds.

CENTERS FOR DISEASE CONTROL

Estimates for Consulting Services

The focal point within the Public Health Service for the prevention and control of diseases and certain other conditions, is the Centers for Disease Control (CDC). CDC has the lead responsibility for responding to health emergencies such as natural disasters, technological hazards, and disease outbreaks. Consultant services are required in most of CDC's activities and are used to add a dimension that enhances program efforts.

Through the use of consultants obtained on an appointive and contractual basis CDC can tap national and international resources, thereby building a base of knowledge in disease control and environmental and occupational safety and health. Advisory committees focus on bringing together individuals from a multiplicity of disciplines. This has proven to be successful in the dissemination and exchange of information related to CDC's missions.

CENTERS FOR DISEASE CONTROL

Estimates for Related Services

Account Title	Type /1	Source of Funds /2	Obligations /3 1985	1986	1987
Disease Control	RD	A	1,047,211	328,000	328,000
Total, related services			1,047,211	328,000	328,000

TOTALS

	1985	1986	1987
Management and professional services	1,034,299	304,000	304,000
Special studies and analyses	12,912	24,000	24,000
Management and support services for research and development activities	-	-	-
Total, related services	1,047,211	328,000	328,000

/1 MP for management and professional services; SA for special studies and analyses; RD for management support services for research and development activities.

/2 A for appropriated funds; N for non-appropriated funds.

/3 Does not include reimbursable such as Agent Orange and Superfund.

CENTERS FOR DISEASE CONTROL

Estimates for Related Services

Through the use of related services, the Centers for Disease Control (CDC) adds a dimension to program efforts that enables us to more effectively meet our responsibilities in leading public health efforts to prevent unnecessary disease, disability, and death, by building our base of knowledge in disease control and environmental and occupational safety and health.

Management and professional services are used by all organizational segments of the Centers for Disease Control in carrying out their day-by-day disease control activities. Special studies and analyses are required for many diseases and disease outbreaks.

Detail of Permananet Positions

	1985 Actual	1986 Estimate	1987 Estimate
ES-5	1	1	1
ES-4	6	6	6
ES-3	1	1	1
ES-2	1	1	1
ES-1	1	1	1
Subtotal	10	10	10
GS/GM-15	118	115	115
GS/GM-14	186	179	179
GS/GM-13	430	421	421
GS-12	469	453	453
GS-11	460	437	437
GS-10	1	1	1
GS-9	375	344	344
GS-8	16	16	16
GS-7	260	237	237
GS-6	259	240	240
GS-5	342	316	316
GS-4	117	114	114
GS-3	6	5	5
GS-2	7	5	5
GS-1	-	-	-
Subtotal	3,046	2,883	2,883

Detail of Permananet Positions - Cont'd

	1985 Actual	1986 Estimate	1987 Estimate
Grades established by Act of July 1, 1944 (42 U.S.C. 207):			
Assistant surgeon general grade 8, $48,834 - $66,398	3	3	3
Assistant surgeon general grade 7, $40,579 - $59,130	4	4	4
Director grade, $30,074 - $51,955	152	152	152
Senior grade, $24,055 - $42,390	197	197	197
Full grade, $20,275 - $35,449	172	172	172
Senior assist. grade, $18,842 - $30,658	97	97	97
Assistant grade, $16,430 - $22,748	14	14	14
Junior assistant grade, $14,263 - $17,942	-	-	-
Subtotal	639	639	639
Grades established by Administrator, Agency for Internat'l Develop. 75 Stat. 450):			
FC-11 $44,430 - $57,759	1	1	1
FC-10 37,599 - 48,876	4	4	4
Subtotal	5	5	5
Ungraded	353	353	353
Total permanent positions	4,053	3,890	3,890
Unfilled positions, end-of-year	-262	-	-
Total permanent employment, end-of-year	3,791	3,890	3,890

BLANK PAGE

WEDNESDAY, MARCH 19, 1986.

OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

WITNESSES

DR. DONALD IAN MACDONALD, ACTING ASSISTANT SECRETARY FOR HEALTH, DEPARTMENT OF HEALTH AND HUMAN SERVICES

WILFORD J. FORBUSH, DEPUTY ASSISTANT SECRETARY FOR HEALTH OPERATIONS AND DIRECTOR, OFFICE OF MANAGEMENT

DR. J. MICHAEL MC GINNIS, DEPUTY ASSISTANT SECRETARY FOR HEALTH (DISEASE PREVENTION AND HEALTH PROMOTION)

JO ANN GASPER, DEPUTY ASSISTANT SECRETARY FOR POPULATION AFFAIRS

DR. MANNING FEINLEIB, DIRECTOR, NATIONAL CENTER FOR HEALTH STATISTICS

JOHN E. MARSHALL, DIRECTOR, NATIONAL CENTER FOR HEALTH SERVICES RESEARCH AND HEALTH CARE TECHNOLOGY ASSESSMENT

DONALD SHOPLAND, ACTING DIRECTOR, OFFICE ON SMOKING AND HEALTH

ASAHEL HAYES, EXECUTIVE DIRECTOR, PRESIDENT'S COUNCIL ON PHYSICAL FITNESS AND SPORTS

DR. WALTER DOWDLE, AIDS COORDINATOR

DR. HERBERT NICKENS, DIRECTOR, OFFICE OF MINORITY HEALTH

W. HARELL LITTLE, CHIEF, BUDGET BRANCH, PUBLIC HEALTH SERVICE

DENNIS P. WILLIAMS, ACTING DEPUTY ASSISTANT SECRETARY, BUDGET

Mr. NATCHER. At this time, we take up the budget request for Fiscal Year 1987 for the Office of the Assistant Secretary for Health. And we have before the Committee at this time, Dr. Donald Macdonald.

Mr. Young, I am going to yield to you at this point.

Mr. YOUNG. Well, Mr. Chairman, thank you very much.

I would like to include my welcome to Dr. Macdonald in as much as he is not only a very distinguished public servant but he just happens to be a constituent of this member of the Subcommittee. And I am satisfied that all those who come in contact with him, in his professional responsibilities, would share in our applause to him for the good job that he has done. And I thank you very much, Mr. Chairman.

Mr. NATCHER. Thank you, Mr. Young.

INTRODUCTION OF WITNESSES

On behalf of the other members of the Subcommittee, Dr. Macdonald, we are delighted to have you before the Committee. And before you proceed with your statement, tell us who you have there at the table with you.

Dr. MACDONALD. At the table I have, at my far right, your far left—Dennis Williams who is the Acting Deputy Assistant Secretary, Budget in the Department. Next to him is Dr. Walter Dowdle, who is acting as the AIDS Coordinator for the Public Health Service.

To my immediate right, Harell Little, the Budget Officer of the Public Health Service. And to my left, Wilford Forbush, who is the Deputy Assistant Secretary for Health Operations.

Mr. **Natcher**. We are delighted to have all of you before the Committee and Dr. Macdonald we would be pleased to hear from you at this time.

Dr. **Macdonald**. Thank you, Mr. Natcher, and thank you, Mr. Young, for your kind remarks.

BUDGET OVERVIEW

I would request that our formal testimony be entered into the record, but I would like to make just a few, relatively brief comments.

We are here today to present three budgets. One is the Public Health Service Management appropriation request for $110.1 million, the Retirement Pay and Medical Benefits for Commissioned Officers appropriation, which is $91.3 million, and the proposal for an AIDS budget in the Office of the Assistant Secretary in the amount of $203.5 million. As you know, the AIDS budget is a new appropriation consolidating funds in the Office of the Assistant Secretary.

Just briefly, about the three budgets. The $110.1 million PHS management budget request represents an increase of $10.3 million over the post-sequester 1986 budget. Of that total, $4.5 million is to restore sequestered funds and the additional $5.8 million is a program increase.

The two programs that will receive the increase are the National Center for Health Services Research and Health Care Technology Assessment, which is, launching their National Medical Expenditures Survey in 1987.

The second increase is a $3.4 million increase for the National Center for Health Statistics, which is getting ready for the data collection cycle of the National Health and Nutrition Examination Survey in 1988.

In the Retirement Pay and Medical Benefits Appropriation, most of those are mandatory increases.

The AIDS budget, as you know, is new in the Office of the Assistant Secretary for Health. The budget that we are asking for, in 1987, is $203.5 million, which represents an increase of $20.3 million over the 1986 level.

In addition to that money, which includes funds that will go to the Centers for Disease Control, the National Institutes of Health, and the Alcohol, Drug Abuse and Mental Health Administration, is an appropriation being asked for by the Food and Drug Administration from a different committee which I will not address here.

I suspect there will be a lot of questions and we look forward to responding.

[The prepared statement of Dr. Macdonald follows:]

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Statement by the Acting Assistant Secretary for Health
on
Budget Request for the Office of the Assistant Secretary for Health

Mr. Chairman and Members of the Committee

I appreciate the opportunity to appear here today to discuss the 1987 budget request for the appropriations in the Office of the Assistant Secretary for Health (OASH)--the Public Health Service (PHS) Management appropriation request of $110.1 million, the Retirement Pay and Medical Benefits for Commissioned Officers appropriation request of $91.3 million, and the Priority Disease Control and Research appropriation request of $203.5 million. The request to consolidate funding for research and the control of Acquired Immune Deficiency Syndrome is a new proposal in 1987. Previously these funds have been requested by the PHS agencies.

PUBLIC HEALTH SERVICE MANAGEMENT

The budget request of $110.1 million for the PHS Management appropriation includes funding for a number of high priority programs which operate under the direct supervision of the Assistant Secretary for Health. These programs account for $91.3 million or 83 percent of the funding requested in this account. The remaining funds support the overall management and direction activities for PHS. The Fiscal Year 1987 appropriation represents a $10.3M increase over the post-sequester 1986 level. This increase includes net program increases totalling $5.8 million and $4.5 million for restoration of amounts sequestered in 1986.

The request includes $18.8 million of budget authority for the National Center for Health Services Research and Health Care Technology Assessment (NCHSR). This is a $3.3 million or 19 percent increase over the post-sequester level. NCHSR supports an extramural research program of investigator-initiated proposals which undergo peer review. These studies make a significant contribution to the expansion of the knowledge base for health policy analysis. Projects focus on the development of methodologies required for future evaluation of alternate mechanisms for organizing, financing and delivering health care, including the creation and validation of methods for determining cost benefit and cost effectiveness. For example, research supported by the Center has documented the extent to which life style changes reduce heart disease deaths. Another project has developed a computer based patient-specific drug therapy monitoring process which improves the quality of care by helping to define more precisely the medication needs of hospitalized patients and which alerts the prescribing physician to possible adverse interactions with other medications which the patient may be receiving. Another NCHSR funded analysis showed that high cost hospital episodes, defined as costing $7,500 or more for inpatient charges, make up only 5 percent of hospital cases but account for 30 percent of all hospital charges.

This budget request includes an increase of $3 million to support the field work for the 1987 National Medical Expenditure Survey (NMES). Even though the last similar household survey was conducted seven years ago, it remains the best available source of information for questions that are being asked by OMB, CPC, HCFA, the Department and congressional committees regarding health insurance coverage and the use of and expenditures for health care services. The data collected by this new survey will be even more useful as a data base for addressing the health care and health insurance policy issues of the 1990s. The NMES scope has been broadened to include institutionalized persons and the expenditures associated with them. In this way we will be better able to address the issues raised by the increasing proportion of elderly Americans, the rapid growth of Medicaid expenditures for care provided for nursing homes and facilities for mentally retarded, as well as for public and private burdens of long term care. The survey will provide an opportunity to update HCFA's Medicare capitation rates for HMOs for the first time since the current Medicare Survey was discontinued in the 1970s. It will also collect data for the Indian Health Service on the health, utilization, and expenditures of American Indians and Alaskan natives in a form that will be comparable to the data for the remainder of the population. This medical expenditure survey is a joint venture between NCHSR and HCFA with important participation by NIMH, the Indian Health Service, and elements of NIH.

The User Liaison Program will be continued as an inhouse effort to broker information between State and local officials and health services research centers in the States.

Another important program included in the request is the National Center for Health Statistics. NCHS is the source of much of the information used to monitor the health of the Nation, follow changes in the use of health services, evaluate relationships between risk factors and health outcomes, and generate hypotheses for biomedical research. Among the most readily recognized and utilized data from NCHS are such key indicators as the infant mortality rate, life expectancy, and causes of death. A wealth of other data provided by NCHS is less well known to the general public, but is heavily relied upon by each of the PHS agencies and by researchers and policymakers elsewhere in the Federal government, the Congress, and the research community.

The budget request of $50 million represents a 12 percent increase over the post-sequester level and includes an increase of $3.4 million for the National Health and Nutrition Examination Survey as it approaches the beginning of its changes in the use of health services, evaluate relationships between risk factors and health outcomes, and generate hypotheses for biomedical research. Among the most readily recognized and utilized data from NCHS are such key indicators as the infant mortality rate, life expectancy, and causes of death. A wealth of other data provided by NCHS is less well known to the general public, but is heavily relied upon by each of the PHS agencies and by researchers and policymakers elsewhere in the Federal government, the Congress, and the research community.

The budget request of $50 million represents a 12 percent increase over the post-sequester level and includes an increase of $3.4 million for the National Health and Nutrition Examination Survey as it approaches the beginning of its data collection cycle in 1988. This survey is a unique source of nutritional, physiological, and diagnostic data, collected through specially designed standardized health examinations. These direct physical examinations, including clinical tests and measurements, are the only source of diagnostic data regarding unrecognized and untreated diseases, and are the best source for standardized clinical, physical, and physiological data on the U.S. population. The last cycle of this survey was completed in 1980, and planning for the 1988 survey is being made in close collaboration with other PHS agencies, the Department of Agriculture and the medical research community. The request for NCHS also provides for the continuation of those data systems that are conducted on an annual basis which include: the National Vital Statistics System, the National Hospital Discharge Survey, and the National Health Interview Survey. As in the past, the level of funding required to support the base program of NCHS fluctuates from year to year depending on the number, and cost, of those periodic surveys that will be conducted in a given year.

Another high-priority program funded in this appropriation is the Adolescent Family Life program. The FY 1987 request of $14.7 million will provide continuation support for the development of innovative, family centered approaches to postpone the onset of teen sexual activity, reduce adolescent pregnancy, develop effective approaches for delivering comprehensive services to the already pregnant adolescent and adolescent parents, and present adoption as a positive alternative to early parenting. Data available on the problem of adolescent pregnancy indicates several disturbing trends: teen sexual activity rates have been rising for most of the past 15 years; sexually active teens are generally not effective or consistent users of contraceptives; and while the teenage birth rate has been declining, there has been an overall increase in the pregnancy rate and a continuing high abortion rate among teenagers. The AFL program is the Department's major focal point for studying the causes and appropriate responses to adolescent sexual behavior, adolescent pregnancy and adolescent parenthood.

The 1987 budget request also includes a total of $7.8 million to continue support for three special-focus activities: health promotion and disease prevention; smoking and health; and physical fitness and sports. These activities are responsible for providing Federal leadership for the prevention of disease and enhancement of health that can be brought about through changes in individual lifestyles and reduction of behavioral and environmental risks. To achieve this mission, the programs foster the development of cooperative relationships with public and private groups and disseminate information via the media, workshops and conferences. In 1987, the Office of Disease Prevention and Health Promotion will focus attention on those 1990 Health Objectives for the Nation where further progress is needed.

In coordination with PHS agencies, the Office of Disease Prevention and Health Promotion will develop and implement a process for establishing health objectives for the year 2000; disseminate recommendations for preventive services in clinical settings; and disseminate the first Surgeon General's Report on Nutrition and Health.

In 1987, the Office on Smoking and Health will undertake a critical evaluation of all the available literature on the health benefits of quitting smoking. This evaluation will serve as the basis for the 1987 Surgeon General's Report on the Health Consequences of Smoking. This report will include an indepth review of the immediate and long term benefits and the clinical effects of quitting smoking. In addition, a significant portion of the report will review the behavioral aspects of quitting by age, race, sex and the role nicotine plays in this process.

In addition to the above prevention initiatives, the Physical Fitness and Sports activity will continue its highly successful program of encouraging physical fitness for all Americans with program emphasis on youth fitness as a follow-up to the National Youth Fitness Survey. Other areas of particular emphasis are fitness for working women, older adults and special populations. Our budget request for these three programs will provide levels of support approximately equal to those in FY 1986.

We are requesting $18.7 million for the management and direction of the Public Health Service, which restores the $1 million amount sequestered in this activity in 1986.

RETIREMENT PAY AND MEDICAL BENEFITS FOR COMMISSIONED OFFICERS

The Retirement Pay and Medical Benefits for Commissioned Officers appropriation funds retirement payments to Public Health Service Commissioned Officers, payments to survivors of officers who elected to receive a reduced annuity, and the costs of medical care of active duty and retired officers, their dependents and survivors.

The Fiscal year 1987 request of $91.3 million includes a cost-of-living- adjustment of 4 percent scheduled for January 1987. However, a legislative proposal was developed and will be sent to Congress in the near future to postpone the 1987 COLA for a savings of $2.2 million. This is in accordance with a government-wide effort to contain cost-of-living adjustments for Federal retirement plans.

The Administration is also proposing to change this account from an indefinite to a definite appropriation. As a result, the amount requested in 1987 includes a $5.0 million reserve fund which will be available only to the extent necessary to pay costs and benefits not anticipated in the budget estimate.

PRIORITY DISEASE CONTROL AND RESEARCH

I am pleased to present, our FY 1987 budget request for Acquired Immune Deficiency Syndrome (AIDS). AIDS is the name given to a complex of health problems first reported in the U.S. in June 1981. AIDS is caused by a virus that is bloodborne and sexually transmitted. Persons afflicted with AIDS suffer a severe loss of natural immunity against disease, leaving them vulnerable to diseases that are not otherwise a threat to most people. These diseases are often referred to as "opportunistic".

Before getting into our request, I would like to share some statistics with you. By February 24, 1986, CDC had received reports of 17,741 AIDS cases (17,489 adults and 252 children) in the U.S. Of these patients, 9,294 (52% of the adults and 60% of the children) are reported to have died, including 71% of patients whose illness was diagnosed before July 1984. AIDS cases have been reported in all 50 States, District of Columbia and 3 U.S. territories. Ninety percent of the cases reported have been among two groups: homosexual and bisexual men, 73%; and persons who inject illicit drugs, 17%. In addition, an estimated 500,000 to 1,000,000 Americans have been infected by the HTLV-III virus. From these statistics one can easily conclude that AIDS has become a disease of epidemic proportion and a public health problem unlike any other in recent history. In combating this problem, we have instituted programs for screening all donated blood in this country; we have required that manufacturers modify their procedures for producing clotting factor for hemophiliacs, rendering this life-giving product free of infectious virus; we have implemented major education/information programs to inform the general public and encourage behavior changes by those at greatest risk of AIDS; and finally, we have established an unprecedented program of epidemiological, clinical, and laboratory research in an effort to further understand the disease and develop effective treatment (drugs) and prevention (vaccines).

Drug Development

One of our highest goals is to speed the discovery, development and testing of drugs against AIDS--and to enable the extramural scientific and medical community and a growing number of AIDS patients to participate in these efforts. This effort is most critical to assist those who now have AIDS, others who may later develop AIDS-related symptoms and still more who are already infected by HTLV-III and may become ill in the future. These efforts will be led by the NIH, particularly NCI and NIAID:

- In a joint project undertaken by the Cancer and Allergy Institutes of the National Institutes of Health, drugs are being screened for their antiviral properties. So far, some 200 drugs have been screened, and several are now in early clinical testing at the National Institutes of Health and elsewhere. Several more antivirals have shown promise in preclinical testing and are being readied for clinical trials.

- To multiply treatment studies around the country, the Cancer and Allergy Institutes in December issued a request for applications for funding of National Cooperative Drug

Discovery Groups. The awards that will be made in the next few months will support laboratory testing and animal studies to discover new agents that inhibit HTLV-III and that restore or maintain immune function.

- The Allergy Institute has also issued a solicitation for establishment of AIDS Treatment Evaluation Units around the country. We expect to establish ten of these units. At these units, antiviral drugs, immune modulators, and antibiotics will be tested in patients with AIDS and AIDS-related complex. We hope within a year to have up to 2,000 patients in treatment. The best minds--both inside and outside the government--are also being brought together to establish criteria for deciding when a drug has shown enough promise in early tests to warrant compassionate release on a broader basis, even though the ultimate value of the drug still must be established by further testing.

Vaccine Development

A second major goal of the PHS is to develop a vaccine. The production of an HTLV-III vaccine presents numerous challenges. Unlike other virus vaccines, neither an attenuated nor a killed whole HTLV-III vaccine would be acceptable because of the undesirable presence of genetic material. However, specific virus proteins have been purified, antibody responses have demonstrated, and these antibodies neutralize HTLV-III in the test tube. The vaccine preparations are now being tested in rhesus monkeys. The next step will be to test the safety and efficacy of these preparations in the chimpanzee, followed by challenge with live virus. These activities will be expanded in 1987.

Prevention Activities - Surveillance, Health Education/Risk Reduction and Public Information

Through the CDC, we will continue national surveillance of AIDS, national and international epidemiological studies to identify new risk factors and further define modes of transmission and the development of prevention strategies to control the spread of AIDS. The goal of PHS's control strategy is to reduce HTLV-III transmission by influencing the behavior of people in three specific population groups. The groups include: (1) those persons infected to prevent further transmission; (2) those high risk groups currently not infected; and (3) the general public. The implementation of this control strategy will be carried out principally through: (1) CDC cooperative agreements with State and local health departments to help intensify surveillance and control activities in high morbidity areas and to develop community health education/risk reduction programs in other areas of the nation. (2) CDC hotline activities aimed toward providing up-to-date information on AIDS to the general but concerned public; and (3) significant expansion of the PHS/OASH comprehensive plan to inform the American public about AIDS in order to create a general awareness and understanding of the syndrome, the ways it is transmitted, and the relative threat it poses to various population groups and to the public health.

FY 1987 Budget Request

The 1987 budget requests that a new appropriation be established within the Office of the Assistant Secretary for Health to consolidate the funding requests for AIDS-related PHS activities, except for the Food and Drug Administration (FDA). The FDA budget is reviewed by the Agriculture, Rural Development and Related Agencies Subcommittee. In the past, funds for AIDS have been requested separately by the Centers for Disease Control, the National Institutes of Health, and the Alcohol, Drug Abuse, and Mental Health Administration. This year we are requesting the single appropriation to assist us in coordinating the total AIDS effort. Approval of this request would enable us to respond more quickly to new scientific breakthroughs and related research and control opportunities. This request also includes $350,000 and 5 FTEs for the AIDS coordinator and staff. AIDS coordinator will be responsible for reviewing and monitoring the AIDS activities being conducted throughout the PHS.

Mr. Chairman, for 1987 we are requesting $203.5 million for AIDS, an a increase of $20.3 million over 1986. This request builds on our accomplishments and primarily expands current NIH research activities, including the development of effective vaccines and drugs.

I will be pleased to answer any questions you may have.

Mr. **Natcher**. Thank you, Dr. Macdonald.

APPOINTMENT OF PERMANENT ASH

Doctor, how long have you been the Acting Assistant Secretary for Health?

Dr. **Macdonald**. Since December 1, 1985.

Mr. **Natcher**. Do you have any idea when a permanent appointment will be made?

Dr. **Macdonald**. I suspect that a permanent appointment will be made in the not-too-distant future. I know that Secretary Bowen has made it one of his goals to quickly bring his organization up to full appointed staff. I cannot give you an exact date, but the appointment should be made soon.

Mr. **Natcher**. How long has it been since we have had a permanent appointment in this assignment?

Dr. **Macdonald**. Dr. Edward Brandt was the last permanent Assistant Secretary. He left office December 31, 1984. So it has been a little over a year.

Mr. **Natcher**. This, I believe, requires Senate concurrence?

Dr. **Macdonald**. Yes, sir.

DUTIES OF THE SURGEON GENERAL

Mr. **Natcher**. Tell us, if you will, what the duties of the Surgeon General are and also tell us how they are separated from those of the Assistant Secretary for Health.

Dr. **Macdonald**. Historically, the Surgeon General's role has been to represent the Public Health Service. In present terms, the Surgeon General performs a number of functions, while reporting directly to the Assistant Secretary for Health.

The functions that the Surgeon General is now involved with include serving as the international health officer for the Public Health Service and representing us at the World Health Assembly, which is an international forum.

As you know, the Surgeon General's report on the health consequences of smoking has been issued under the auspices of his office for a number of years. I am accompanied today by Donald Shopland—sitting behind me—who is the acting director of the Office on Smoking and Health. This office is responsible for preparing that report.

The Surgeon General is, at the request of the President, preparing a report to the Nation on AIDS, which should be out sometime this summer.

The Surgeon General supports the Office of the Assistant Secretary for Health and serves as the head of the Commissioned Officers Corps.

COMMISSIONED CORPS

Mr. **Natcher**. How many members do we currently have in the Public Health Service Commissioned Corps?

Dr. **Macdonald**. I do not have the exact number. Somewhere around 5,400.

Mr. **Forbush**. A little less than 5,400.

Mr. **Natcher**. Has that number remained about the same in recent years?

Dr. **Macdonald**. It has stayed fairly stable over the last couple of years.

Mr. **Natcher**. For the record, if you will, Doctor, provide the pay range for the Commissioned Corps and also describe the various bonuses and allowances that are available.

[Information to be furnished follows:]

COMMISSIONED OFFICERS-SPECIAL PAY

Dr. Macdonald. Commissioned Officers of the Public Health Service receive base pay, allowances and special pays as provided in Title 37, U.S. Code for members of the uniformed services.

Table 1 describes basic rates of pay and allowances. The Surgeon General of the Public Health Service is paid at the 0-9 grade. A small number - limited by law to no more than one percent of the active duty strength - are paid at the 0-7 and 0-8 pay grades when assigned to designated key program positions.

Tables 2 and 3 describe special and bonus pays available to qualified Medical and Dental Officers of the Public Health Service.

Officers may also receive a Variable Housing Allowance when assigned to a designated high cost Military Housing Area. The amount of this allowance is established under procedures managed by the Joint Committee for Per Diem, Travel and Transportation. For example under these procedures, a medical Officer (0-4) assigned to the Indian Health Service at Crow Agency, Montana, qualifies for a monthly payment of $59.64. A Medical Officer (0-5) assigned to the Indian Health Service hospital at Gallup, New Mexico, qualifies for $31.35 per month.

TABLE I

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
PAY AND ALLOWANCES OF COMMISSIONED OFFICERS
EFFECTIVE OCTOBER 1, 1985
(PUBLIC LAW 99-145, NOVEMBER 8, 1985)

	MONTHLY RATES OF BASIC PAY														QUARTERS		
	CUMULATIVE YEARS OF SERVICE														ALLOWANCE		
PAY GRADE	2 OR LESS	OVER 2	OVER 3	OVER 4	OVER 6	OVER 8	OVER 10	OVER 12	OVER 14	OVER 16	OVER 18	OVER 20	OVER 22	OVER 26	WITH DEPS	W/O DEPENDENTS FULL (1)	W/O DEPENDENTS PARTIAL (2)
0-9	4627.80	4749.00	4850.10	4850.10	4850.10	4973.40	4973.40	5180.40	5180.40	5612.70	5612.70	6042.30*	6042.30*	6474.60*	680.70	553.50	50.70
0-8	4191.60	4317.00	4419.60	4419.60	4419.60	4749.00	4749.00	4973.40	4973.40	5180.40	5405.40	5612.70	5837.70*	5837.70*	680.70	553.50	50.70
0-7	3483.00	3719.70	3719.70	3719.70	3886.20	3886.20	4111.80	4111.80	4317.00	4749.00	5075.40	5075.40	5075.40	5075.40	680.70	553.50	50.70
0-6	2581.50	2836.20	3021.90	3021.90	3021.90	3021.90	3021.90	3021.90	3124.50	3618.60	3803.70	3886.20	4111.80	4459.50	617.40	507.90	39.60
0-5	2064.60	2424.60	2592.00	2592.00	2592.00	2592.00	2670.60	2814.00	3002.70	3227.10	3412.50	3515.70	3638.40	3638.40	568.80	479.40	33.00
0-4	1740.30	2119.20	2260.50	2260.50	2302.50	2404.20	2568.00	2712.60	2836.20	2960.70	3042.60	3042.60	3042.60	3042.60	519.90	439.50	26.70
0-3	1617.30	1808.10	1932.90	2138.70	2241.00	2321.70	2447.10	2568.00	2631.30	2631.30	2631.30	2631.30	2631.30	2631.30	433.50	355.80	22.20
0-2	1410.30	1540.20	1850.10	1912.50	1952.70	1952.70	1952.70	1952.70	1952.70	1952.70	1952.70	1952.70	1952.70	1952.70	371.70	286.50	17.70
0-1	1224.30	1274.70	1540.20	1540.20	1540.20	1540.20	1540.20	1540.20	1540.20	1540.20	1540.20	1540.20	1540.20	1540.20	333.30	245.70	13.20

Above table does not apply to commissioned officers who have been credited with over 4 years of active service as an enlisted member (see table below)

COMMISSIONED OFFICERS WHO HAVE BEEN CREDITED WITH OVER 4 YEARS ACTIVE SURVICE AS AN ENLISTED MEMBER

PAY GRADE	OVER 4	OVER 6	OVER 8	OVER 10	OVER 12	OVER 14	OVER 16	OVER 18	OVER 20	OVER 22	OVER 26	WITH DEPS	W/O DEPENDENTS FULL (1)	W/O DEPENDENTS PARTIAL (2)
0-3E	2138.70	2241.00	2321.70	2447.10	2568.00	2670.60	2670.60	2670.60	2670.60	2670.60	2670.60	433.50	355.80	22.20
0-2E	1912.50	1952.70	2014.50	2119.20	2200.20	2260.50	2260.50	2260.50	2260.50	2260.50	2260.50	371.70	286.50	17.70
0-1E	1540.20	1645.20	1705.80	1767.60	1829.10	1912.50	1912.50	1912.50	1912.50	1912.50	1912.50	333.30	245.70	13.20

BLANK PAGE

BLANK PAGE

BLANK PAGE

Additional pay as applicable:

(1) For all officers Basic Allowance for Subsistence is $109.37 per month.

(2) A Variable Housing Allowance for officers whose duty stations are in designated "high housing cost areas"

(3) Medical and dental officers called to active duty for one year or more, if otherwise eligible, are entitled to Variable Special Pay, Board Certified Pay, Retention Special Pay, and Additional Special Pay.

(4) Veterinary and Optometry officers called to active duty for one year or more, if otherwise eligible, are entitled to $100.00 month Special Pay.

*Basic Pay is limited to $5724.90 per month (Level V of the Executive Schedule)

Quarters and Subsistence are non-taxable allowances.

(1) Payment of the full rate of basic allowance for quarters at these rates for members of the uniformed services without dependents is authorized by 37 U.S.C. 403 and Part IV of Executive Order 11157 as amended.

(2) Payment of the partial rate of basic allowances for quarters at these rates for members of the uniformed services without dependents who, under 37 U.S.C. 403(b) or 403(c) would be entitled to the full rate of basic allowance for quarters if not assigned to bachelor-type government quarters is authorized by 37 U.S.C. 1009(d) and Part IV of Executive Order 11157, as amended.

TABLE 2

RATES OF SPECIAL PAY FOR MEDICAL OFFICERS

Grade or Status	Years of Creditable Service 1/	Variable Special Pay 2/	Board Certified Pay 2/	Retention Special Pay 3/4/5/	Maximum Special Pay 6/
Interns	N/A	1,200	N/A	N/A	1,200
01-06	Less than 6 yrs.	5,000	2,000	9,000	16,000
01-06	At least 6 but less than 8 yrs.	10,000	2,000	9,000	21,000
01-06	At least 8 but less than 10 yrs.	9,500	2,000	9,000	20,500
01-06	At least 10 but less than 12 yrs.	9,000	2,500	10,000	21,500
01-06	At least 12 but less than 14 yrs.	8,000	3,000	10,000	21,000
01-06	At least 14 but less than 18 yrs.	7,000	4,000	10,000	21,000
01-06	At least 18 but less than 22 yrs.	6,000	5,000	10,000	21,000
01-06	At least 22 yrs.	5,000	5,000	10,000	20,000
07-09	Less than 10 yrs.	1,000	2,000	9,000	12,000
07-09	At least 10 but less than 12 yrs.	1,000	2,500	10,000	13,500
07-09	At least 12 but less than 14 yrs.	1,000	3,000	10,000	14,000
07-09	At least 14 but less than 18 yrs.	1,000	4,000	10,000	15,000
07-09	At least 18 yrs.	1,000	5,000	10,000	16,000

1/ Civilian internship and residency training and active service as a physician in the uniformed services.

2/ Payable in equal monthly installments. Payable to residents and officers with active-duty obligations.

TABLE 2 (cont'd)

RATES OF SPECIAL PAY FOR MEDICAL OFFICERS (cont'd)

3/ Must execute RSP contract to be considered for annual RSP payment.

4/ Officers in medical internships or in initial residency training not eligible.

5/ Officers who do not serve on active duty for the entire period for which they had received RSP will be required to refund a pro rata portion of any payment received which represents the unexpired part of their active-duty obligation and will be divested of entitlements for travel and transportation allowances, shipments of household goods, and transfer of or payment for unused annual leave.

6/ Maximum amount of special pay a medical officer can receive provided he/she is eligible and qualified for each special pay element.

TABLE 3

Rates of Special Pay For Dental Officers

Proposed legislation currently before the Congress will, effective October 1, 1985 if enacted, change drastically the way dentists are paid special pay. In general, the monthly dental special pay will be eliminated and replaced by a Variable Special Pay (VSP) and a Board Certified Pay (BCP). The bonus pay currently titled Continuation Pay (CP) will be renamed "Additional Special Pay" (ASP) and will have no connection to the member's basic pay.

Each of the three pays referenced above will be paid based on the officer's creditable service entry date (CSED) and his/her grade as follows:

GRADE	CREDITABLE SERVICE	VARIABLE SPECIAL PAY (PER YEAR)	MONTHLY RATE
01-06	INTERN	1,200	100.00
01-06	Less than 3 years	1,200	100.00
01-06	At least 3 but Less than 6	2,000	166.66
01-06	At least 6 but less than 10	4,000	333.33
01-06	At least 10 but less than 14	6,000	500.00
01-06	At least 14 but less than 18	4,000	333.33
01-06	At least 18	3,000	250.00
07-10	Not Applicable	1,000	83.33

GRADE	CREDITABLE SERVICE	BOARD CERTIFIED PAY (PER YEAR)	MONTHLY RATE
01-10	Less than 12 years	2,000	166.66
01-10	At least 12 but less than 14	3,000	250.00
01-10	At least 14	4,000	333.33

GRADE	CREDITABLE SERVICE	ADDITIONAL SPECIAL PAY	REMARKS
01-10	At least 3 but less than 14	6,000	PAID ANNUALLY AT BEGINNING OF CONTRACT PERIOD. CANNOT BE PARTICIPATING IN AN INTERNSHIP OR RESIDENCY TRAINING PROGRAM.
01-10	At least 14 but less than 18	8,000	
01-10	At least 18	10,000	

The Secretary of Defense is required to establish rules for determining if:

a. An officer is undergoing internship or residency training and

b. An officer is board certified.

UNAUTHORIZED PROGRAMS

Mr. **Natcher**. What portion of your 1987 budget request is currently not authorized?

Dr. **Macdonald**. Funding for the Adolescent Family Life program in Title XX is not authorized as well as the Title X money. The totals of that are $14.7 million for Title XX and $142 million for Title X for which we have requested a block grant authorization in 1987.

Mr. **Natcher**. Title X is not part of this account, though?

Mr. **Forbush**. Title X is not part of this appropriation, Mr. Chairman.

GRAMM-RUDMAN-HOLLINGS REDUCTION

Mr. **Natcher**. All right. Pursuant to the Gramm-Rudman Law, your management account was reduced by $4,481,000 in 1986. What effect will this reduction have Doctor?

Dr. **Macdonald**. That decrease of $4.5 million has been handled a little differently in the various program offices. In the Office of Management the reduction has been accomplished by postponing travel, deferring the purchase of equipment, delaying the filling of vacancies and delaying promotions.

The largest part of that reduction, approximately $2 million, was taken by the National Center for Health Statistics. They have postponed purchasing vital statistics data for three months. By delaying, they have picked up that one-time saving.

Across the board, there have been decreases in all the programs.

Mr. **Natcher**. Will there be any employee furloughs in 1986?

Dr. **Macdonald**. No, sir.

Mr. **Natcher**. How much of the 1986 reduction is restored in the 1987 budget?

Dr. **Macdonald**. In terms of dollars, it is all restored.

Mr. **Natcher**. At this point in the record, we will insert your report to the Committee on sequestration.

[Information to be furnished follows:]

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PUBLIC HEALTH SERVICE

Public Health Service Management

Effects of Sequestration

Program/Activity	FY 1986 Appro.	Sequestration	FY 1986 Available After Sequestration
Health services research/HCTA:			
Program operations.....	$14,804,000	-$637,000	$14,167,000
Program support........	1,638,000	-70,000	1,568,000
Subtotal............	16,442,000	-707,000	15,735,000
Health statistics:			
Program operations.....	43,491,000	-1,870,000	41,621,000
Program support........	3,193,000	-137,000	3,056,000
Subtotal............	46,684,000	-2,007,000	44,677,000
Adolescent family life...	14,689,000	-632,000	14,057,000
Health initiatives:			
Smoking and healt......	3,526,000	-151,000	3,375,000
Disease prevention and health promotion......	3,000,000	-129,000	2,871,000
Physical fitness & sports	1,379,000	-59,000	1,320,000
Subtotal............	7,905,000	-339,000	7,566,000
PHS management...........	18,510,000	-796,000	17,714,000
Total.............	104,230,000	-4,481,000	99,749,000

Effect of Sequestration - Impact of The Balanced Budget and Emergency Deficit Control Act of 1985

Health Services Research and Health Care Technology Assessment

In FY 1986 this budget activity is being reduced by $707,000 as a result of sequestration. Of this amount, the Program Operations activity will be reduced by $637,000 and the Program Support activity will be reduced by $70,000. The Program Operations activity includes an intramural and extramural research component and a mandate to support the activities of a User Liaison Program which is partially responsible for the dissemination of health services research results. The Program Support activity provides for the planning, coordination, and management of health services research programs.

The FY 1986 target will be met by restructuring the User Liaison Program, reducing travel expenditures and reducing the cost of program planning, coordination and management.

The User Liaison Program currently operates largely through contractor support for meetings to disseminate and discuss health services research as well as for provision of technical assistance to State and local governments. The majority of these funds (60%) are expended on travel and subsistence for individuals from state governments attending these workshops and for support and contractor overhead. Since at least 24 states now have one or more health services research centers in the State, we will restructure the program as a coordination and referral service to enable States and local officials to work with their own resources rather than using a Federal subsidy. State and local personnel will be referred to the research center most geographically convenient and the Federal staff will continue to provide brokering services and technical assistance in lieu of directly sponsoring workshops.

Health Statistics

Program Operations

In FY 1986, this activity is being reduced by $1,870,000 as a result of sequestration.

The National Center for Health Statistics maintains a Nation-wide vital statistics network with the states for the purpose of collecting national data on vital events occurring in the United States on an annual basis. These data are purchased from 54 states/registration areas.

In order to accommodate this reduction the Center will adjust the contract period for the procurement of this data, with no effect on program operations.

Program Support

In FY 1986, NCHS program support is being reduced by $137,000 as a result of sequestration. NCHS will reduce training support and associated travel by approximately 34% to accommodate the sequestration. In addition, plans to purchase equipment will have to be delayed.

Adolescent Family Life

In FY 1986, this account is being reduced by $632,000 as a result of sequestration. This will require reductions in the dollar levels awarded to grantees. The program will continue to maintain the same number of grant awards planned in FY 1986. This approach will allow the program to reach the same number of clients as originally proposed.

Smoking and Health

In FY 1986, this activity is being reduced by $151,000 as a result of sequestration. This reduction will delay a project on the prevalence of cigarette use and use of smokeless tobacco products among teenagers and adolescents.

Disease Prevention and Health Promotion

In FY 1986, this account is being reduced by $129,000 as a result of sequestration. This will result in a reduction in the scope of the Program's national public education program, "Healthy Older People" and in the level of support provided to the Workplace Health Fund cooperative agreement, the National Health Information Clearinghouse, and the United States Preventive Services Task Force.

Physical Fitness and Sports

In FY 1986, this account is being reduced by $59,000 as a result of sequestration. General publications and leadership training aids and materials on physical fitness for youth, abled and disabled, will be continued at a reduced level.

Public Health Service Management

In FY 1986, this account is being reduced by $796,000 as a result of sequestration. There are several management actions which will be taken to accommodate the reduced funding level. For example, filling of vacancies will be delayed to recoup salary savings; planned travel will be reduced; purchases of equipment to continue the automation plan will be postponed; and training will be postponed or eliminated. A portion of this one-time reduction can be absorbed in FY 1986 because the position of Assistant Secretary for Health has been vacant and the salary, travel and related expenses have not been incurred. These funds will be required in FY 1987.

RETIRED PAY COLA

Mr. **Natcher**. What effect, Doctor, did Gramm-Rudman have on the retired pay account in 1986?

Mr. **Forbush**. The cost-of-living adjustment was postponed which produced some savings.

Mr. **Natcher**. Do you have, also, a plan to eliminate the cost of living increase in Fiscal 1987?

Mr. **Forbush**. Yes, sir. There is a separate legislative proposal that will postpone the increase. Although the cost-of-living delay is not reflected in our 1987 budget, a proposal will be submitted.

Mr. **Natcher**. Well, why do this two years in a row? What is the reason for it?

Mr. **Forbush**. This is part of a proposal that would affect all of the civilian and military retirement pay. We are part of that government-wide proposal.

AIDS PROGRAM CONSOLIDATION

Mr. **Natcher**. You are proposing to have one consolidated account for all AIDS activities in 1987 under the Assistant Secretary for Health. Why is this being proposed?

Dr. **Macdonald**. There are really three reasons that we are consolidating or centralizing AIDS resources. One is to better highlight the AIDS effort. There has been some criticism that there has not been a central focus for this effort. We hope that in appointing Walter Dowdle to the post of AIDS coordinator, we have that central focal point.

The second is to help us with planning. The historic way that the AIDS effort has developed is with a planning group set up by Dr. Brandt called the AIDS Executive Task Force. Consolidation will focus the Task Force under a full time coordinator.

The third reason is to coordinate the AIDS research and dollar amounts, in terms of our requests to Congress.

Mr. **Natcher**. Who would control the allocation of funds from this account?

Dr. **Macdonald**. The way the process has worked, and worked very well, is that the institutes within the Public Health Service and the bureaus of CDC would submit their budgets to their agency heads. Those budgets would be discussed by the AIDS Executive Task Force, which has on it representatives from all of the agencies. From that discussion, a recommendation is made and the final say is made by the Assistant Secretary for Health.

Mr. **Natcher**. Mr. Young, I yield to you.

Mr. **Young**. Thank you very much, Mr. Chairman.

AIDS CASES IN FLORIDA

While we are on the subject of AIDS, you know, Dr. Macdonald, Florida has been one of the states most affected by AIDS. More than 1250 cases have been reported in Florida since 1980 and the mortality rate has exceeded 50 percent. 37 cases have been reported in our county and 19 of those patients have died. Jackson Memorial Hospital in Miami has handled an extremely heavy AIDS case load.

And Mr. Chairman, I would like to include, for the record, a letter that I received from Jackson Memorial yesterday describing the impact that AIDS has had on their facility. The information from Jackson Memorial raises a concern that growing numbers of children are becoming the victim of AIDS. Jackson Memorial has treated 82 children under the age of 13 with the AIDS virus. 27 of these children died.

[The information follows:]

JACKSON MEMORIAL HOSPITAL
1611 N.W. 12th AVENUE • MIAMI, FLORIDA 33136

March 17, 1986

The Honorable C. W. (Bill) Young
2266 Rayburn House Office Building
Washington, D.C. 20515

Dear Congressman Young:

The University of Miami/Jackson Memorial Medical Center is the major resource for the primary and secondary care of patients with AIDS/ARC (AIDS related cases) in Florida.

Since the outbreak of the AIDS epidemic, half of all the AIDS cases and related deaths occurring in Florida have occurred in Dade County. Since 1979, more than 1,500 adult patients with AIDS or an AIDS-related illness have been evaluated at the Medical Center, and the number of patients seeking care continues to increase geometrically. This patient utilization has significantly impacted the Medical Center's inpatient and outpatient services.

An even greater tragedy is the impact of AIDS upon children. Since 1979, 82 children under the age of 13 with HTLV-III virus infection (Human T-Lymphotropic Virus Type III) have been identified at Jackson Memorial Hospital. Thirty-eight of these children meet criteria for the diagnosis of AIDS. Twenty-seven have died. The majority of these children reside in Dade County, but children from other counties in South Florida have also been seen.

Since January, 1985, 25 new AIDS cases have been identified. Each year the number of children identified has increased and it is projected that as many as 35 new cases will be identified in 1986. These children usually present early in life with illness and require frequent and prolonged hospitalizations. In some instances, children have required as many as 11 hospitalizations during the first two years of life. The census for this diagnosis on the pediatric floor varies from 1 to as many as 15 patients, with a current average census of approximately six. Since some parents are unable to care for their children, the children become wards of the state. Foster care for these children is extremely difficult to arrange, resulting in prolonged hospitalizations of several months although the children may not be actually ill.

The nature of AIDS is that of a severe, unrelenting disease complicated by persistent and recurrent infections that require close medical supervision and frequent emergency evaluation. Under the present circumstances it is particularly difficult to adequately provide services for numerous unscheduled visits, and the availability of limited resources results in frequent emergency room visits, additional hospitalizations, and increased inpatient lengths of stay. Inpatients with AIDS suffer from a multiplicity of health problems and are therefore high acuity level admissions. Consequently, these patients demand a great amount of direct patient care from physicians, nurses and ancillary personnel.

It is critical that funds be made available for the operation of these clinical units providing treatment and increasing medical knowledge relating to this dread disease.

Your cooperation and that of your committee in furnishing funds for demonstration projects in this regard is urgently needed and greatly appreciated.

Sincerely,

Leon W. Zucker
Vice President for Finance
Public Health Trust

LWZ/dl

cc: Ms. Martha Davidson
State of Florida/Washington Office
Suite 287
444 N. Capitol Street
Washington, D.C. 20001

Mr. **YOUNG**. With the current trend, Jackson Memorial officials expect to treat 35 new children's AIDS cases in 1986. Florida officials are, I think, legitimately concerned about the AIDS research and treatment programs.

AIDS OFF-SITE TEST PROGRAM

First, there is a $10 million funding for alternate site testing. Florida has received a $950,000 grant this year, as part of this program, to operate AIDS testing and counseling services throughout the state.

What is your Department's funding request for the program in 1987?

Dr. **MACDONALD**. Mr. Young, are you speaking about the AIDS request totally or the alternate AIDS blood testing sites.

Mr. **YOUNG**. I am talking about the $10 million for Fiscal Year '86, and the FY '87 request for the same program?

Dr. **MACDONALD**. The offsite test program was set up in FY 1985 as a one year, $10.4 million government project to stimulate the development of alternate test centers. The program was not proposed for continuation in either 1986 or 1987. It was clearly our understanding that it was a one-year project.

In 1986, Congress added $10 million to the budget for continuation of support to local efforts for AIDS alternative blood testing sites. As these funds are in excess of our identified needs, we have proposed the $10 million for rescission in FY 1986. Further, we are not requesting an additional $10 million for this program in FY 1987.

Mr. **YOUNG**. There is nothing in the '87 budget——

Dr. **MACDONALD**. No, not for that purpose. We had been led to understand—and I would like Dr. Dowdle to comment—that the states have seen the value of these alternative test sites and are, indeed, making plans on their own to continue with them.

Dr. Dowdle?

Dr. **DOWDLE**. Most of the states, in fact, have had their project periods extended because the funds were not totally expended during the year in which they were actually funded. In many states, their federal support will end in April of this year.

I think that from the standpoint of their interest, both from the state and local level, they feel that the testing site—which they now prefer to call them, rather than alternate test sites—is a major service that the state can provide for AIDS.

Mr. **YOUNG**. What you are saying is that the federal government believes you have got the program started and now it is up to the states to carry it on? Is that basically what you are saying?

Dr. **MACDONALD**. Yes, that is it.

Dr. **DOWDLE**. That was the intent. The initial money was awarded for a 90-day period which was extended because all of the funds were not expended during that time. That extension was over a year ago.

AIDS TREATMENT PROGRAMS

Mr. **YOUNG**. The newly-established Federal AIDS treatment program, it is my understanding, is funded at $34 million for fiscal year 1986. What is the funding request for fiscal year 1987 for that program?

Dr. MACDONALD. There are a number of programs dealing with the treatment of AIDS. I am not sure which program you are addressing. There is $20 million proposed this year for clinical trials, the testing of five or perhaps more agents that look like they may have some value for testing in humans. However, as I said that is a $20 million request. I am not sure what the $34 million program is.

Mr. YOUNG. Well, we identify it as the Federal AIDS treatment program.

Dr. MACDONALD. There is an additional $16 million that was included in the 1986 appropriations bill by the Senate to fund four AIDS treatment demonstration efforts in different geographic locations. We are proposing to rescind this $16 million in 1986 as an unnecessary Federal project. Again, this is only $16 million, not $34 million.

Mr. FORBUSH. Mr. Young, might you be referring to the estimate of spending under Medicare and Medicaid for people with the disease?

Mr. YOUNG. Well, maybe I have identified it improperly, and if that is the case, I will review my information on it and I will communicate that to you.

Dr. MACDONALD. I can give you some information on Federal funding for AIDS treatment where patients qualify. It is estimated that Medicaid will spend $100 million in fiscal year 1986. The Veterans Administration will spend an estimated $40 million on payments for veterans.

In addition, there are other funds that will go for treatment from alcohol, drug abuse, and mental health block grant, and from the minority health task force money. There are lots of little pieces. I'm not sure what the $34 million represents, though.

Mr. YOUNG. Well, those are not the ones I am referring to, but I will identify it. I will get your account ledger and identify it that way for you.

Dr. MACDONALD. Thank you, sir.

CHILDHOOD IMMUNIZATION

Mr. YOUNG. Before you joined the ranks of the bureaucracy, Doctor, you had an enviable reputation in our community as a pediatrician. With your expertise in this field, I'm sure the committee would be interested in your views concerning the situation of shortages of childhood immunization vaccines.

Liability claims and the threat of litigation have forced some of the pharmaceutical firms to discontinue the production of vaccines. Last year during our hearings, I raised this issue and we were told at that time that there was a sufficient supply of vaccine stockpiled for that year.

I am curious now what is the situation for this year. Is the stockpile still there or is it diminishing?

Dr. MACDONALD. The stockpile is not diminishing, but we are indeed concerned about possible problems in the pertussis vaccine, particularly. I think the stockpile presently is 17 weeks of the material available. There are tremendous liability questions in terms of who is going to reinsure Lederle or Connaught, the two American manufacturers of that vaccine. We are spending a fair amount of time trying to get ahead of that problem, and I would agree with you it is a major concern.

Mr. YOUNG. It is a major concern. Is it something that we need to be involved with? Are you going to take care of it? I mean what should we be doing?

Dr. MACDONALD. I think the major issues are—and I don't know if it falls within the domain of this—two concerns. One of which is looking for a vaccine that is more or less free of side effects. We have trials going in Sweden and elsewhere, but those are probably three years away from yielding the results that are going to help us in the crisis.

The other major issue relates to liability. That issue is in many people's minds and it is broader than just pertussis. The Justice Department is working on a bill and I know there are several bills in Congress trying to in some way address that problem. We would welcome everybody's support.

PERTUSSIS VACCINE

Mr. YOUNG. Is pertussis the main concern now in the vaccine?

Dr. MACDONALD. Yes. Pertussis is the main concern. Pertussis is usually given to infants, packaged with two other vaccines, diphtheria and tetanus, and those two are less likely to cause reactions and are less involved with liability cases.

HOSPITALIZATION DENIED FOR REYES SYNDROME PATIENT

Mr. YOUNG. Let me ask you one more question. You were here last week when Dr. Bowen made his first appearance before the committee, and maybe you remember I discussed with him at length the issue of the Reyes syndrome case in our county where the young child was denied hospitalization because of a question as to whether or not the parents had hospital insurance. Do you have any comments or thoughts that you would like to share with the committee on the subject of a child or someone with a life-threatening disease being denied hospitalization?

Dr. MACDONALD. I thought it was a terrible situation. I don't know what response you will get on the record from the Secretary, but it was a little different, Mr. Young, than the usual case where a child goes to a hospital and is denied treatment. In this one, he went to a hospital, had the correct diagnosis, and the hospital wanted to refer him not because of economic reasons but because they felt, and I think appropriately, that they were not able to handle it. Then it was a matter of looking for a hospital that would accept him, have beds and money and availability. I feel very strongly personally about hospitals that would refuse any child on that basis.

I don't know from the story whether it was a matter of beds in this situation. As I am sure you recall, in the neonatal problem in Florida a few years ago, we established a hotline because infants were being refused, not because of economic reasons but because of facility availability. In this situation, I wasn't sure which of those came into play.

Mr. YOUNG. Well, this was a rather lengthy situation. There were several hospitals that did not have a bed for him, one who refused him over the issue of insurance, and he finally was transferred to Gainesville and then ended up in a hospital in Jacksonville. Fortunately, his life was saved, and apparently there were no follow-up problems, but at the time it appeared that he could have lost his life from this.

Well, I appreciate your comments on all these issues. I had some other questions that I want to submit to you in writing, and I would appreciate your response.

Mr. Chairman, I thank you very much.

Mr. NATCHER. Mr. Early.

Mr. EARLY. Thank you, Mr. Chairman.

AIDS APPROPRIATION LANGUAGE

Dr. Macdonald, for 1987, the budget proposes to appropriate funds for AIDS-related activities to the Office of the Assistant Secretary of Health. The justifications state that appropriation bill language is being requested to provide funding for coordination, research and education activity on AIDS.

The bill language states in part, "For carrying out Title III of the Public Health Service Act with respect to priority projects, $203,482,000."

Doctor, briefly summarize the activities authorized under Title III.

Dr. MACDONALD. Research and education.

Mr. FORBUSH. Title III is a very broad section of the Public Health Service Act. Section 301 authorizes research in practically any area.

Mr. EARLY. Okay. It would appear that this language does not restrict OASH to using the funds for AIDS; is that correct?

Dr. MACDONALD. Correct.

Mr. FORBUSH. Yes. OMB designed it for other uses—they call it priority disease prevention and control, but it is for AIDS. The only purpose——

Mr. EARLY. Well, if OMB designed it, and I have reservations on what they design, wouldn't this language permit OASH to utilize these funds for other than AIDS-related activities?

Mr. FORBUSH. It would. It is not our intention to do so, but it would.

Mr. EARLY. Doctor, who would make the determination as to what is the priority project?

AIDS EXECUTIVE TASK FORCE

Dr. MACDONALD. Let me just run through the process by which we got to where we are, and maybe that best explains it. When AIDS became a problem that we were aware of in the early 1980s, Dr. Edward Brandt, then Assistant Secretary for Health, I think to his great credit, saw something coming that was a lot bigger than most people saw. Very early on, he appointed an AIDS Executive Task Force which he chaired and which met on a regular basis to deal with problems as they were emerging.

That task force in many ways became the policy board for deciding which way to go with AIDS. It consisted of a representative from each of the Public Health Service agencies. Over time, they developed a policy that is written in terms of the strategy that the Public Health Service would take.

In Dr. James Mason's tenure as Acting Assistant Secretary, the problem had grown considerably more rapidly. Dr. Mason found himself spending more than a little of his time as the AIDS coordinator while serving as Acting Assistant Secretary for Health.

When I came to this job in early December, it was pointed out to me by several wise people that it had gotten so big that I couldn't really do both jobs full time. So I asked Walter Dowdle to come on detail as the AIDS coordinator for the Assistant Secretary for Health. What Walter does now is chair that task force and invite comments from them. There is a collegiality that goes in that group that makes decisions jointly, and so far, I think very well.

AIDS APPROPRIATION LANGUAGE

Mr. EARLY. Doctor, why is it necessary to include language authorizing and, in effect, transferring any unobligated funds to this account?

Dr. MACDONALD We believe that should the Institutes reach the end of the year and find they don't have time to make a particular award, it would be helpful to have that money available for the subsequent year as opposed to having to rush like mad and make that final award.

Mr. EARLY. I agree with that, but in a lot of accounts, we just have prior appropriation continued in that specific account. So this would apply to the 1986 funds also?

Dr. MACDONALD. No, just 1987.

Mr. EARLY. Just 1987.

Doctor, isn't it possible that an agency may have plans for some of its funds but, because of the mechanics of the process, is unable to obligate these funds?

Dr. MACDONALD. I guess that is possible. One of the things that we have to be aware of are continuation costs and costs of obligations that have been out ahead of time.

Mr. EARLY. Will the agency lose these funds to this account in a case like this?

Dr. MACDONALD. Not under the proposal.

Mr. EARLY. Then the answer is no.

Doctor, during our hearings over the past couple of weeks, the program has been described as a consolidation of funds appropriated for AIDS activity, yet in reviewing the request, I see that you are also proposing bill language which would authorize the Secretary to transfer up to one percent of all Public Health Service appropriation funds to this account.

What is your rationale for that?

Dr. MACDONALD. The rationale is that none of us predicted how rapidly the AIDS budget would grow. This is really a way, without coming back to Congress and requesting more money, of finding additional resources if some area of research—vaccine development, for instance—seems to need more money. We now have a mechanism for doing that within the present budget.

Mr. EARLY. So this would give you the authority to transfer more than the amount that you requested without any congressional review of the basis or the need for more funds, the impact on a program and activities that are the sources of the transfer, or any other congressional approval?

Dr. MACDONALD. We would do nothing of this nature without coming to Congress.

Mr. EARLY. I know, but I don't know why, if you are not going to do it, why authorize it in the language. Doctor, given the 1987 budget request, what is the maximum amount that could be transferred under this provision?

Dr. MACDONALD. $86.8 million.

Mr. EARLY. Okay, $86.8 million. So you could within this authorization, without any committee approval, without any congressional approval, just on your own or at the direction of OMB, transfer these monies?

Dr. MACDONALD. Yes, sir.

Mr. EARLY. Would HHS be able to transfer funds from PHS programs so as to eliminate that program? For example, say Congress included $5 million for exceptional financial need scholarships in the HRSA appropriation. Are there any legal restrictions that would preclude HHS from transferring all $5 million to this account?

Dr. MACDONALD. The answer is no, that would not happen.

Mr. EARLY. You keep saying that would not happen. Why do you want an authorization to do that? You just suggested that you could transfer $86.8 million without even coming up to Congress or even coming in on a—that is disturbing to me.

Doctor, I want to stay within my ten minutes here. Do you coordinate the monies, or Dr. Dowdle, or ADAMHA?

Dr. MACDONALD. Yes. In a sense that is the way the budget is developed. When the money comes as appropriated to NIMH, it goes to NIMH. In the terms of putting the proposed budget all together, however the cycle is for each agency or each institute, like the Drug Institute, to submit to ADAMHA a budget request. This budget is then coordinated in that sense.

Mr. EARLY. So the answer is yes?

Dr. MACDONALD. The answer is yes.

AIDS RESOURCES IN DOD

Mr. EARLY. What about defense? First of all, how much does DOD have for AIDS, Doctor?

Dr. DOWDLE. It is about $82 million. It is $40 million for research and $42 million for health care and testing.

Mr. EARLY. You know, that is the number they used the other day, Doctor, but as I researched it, I think it is closer to $95 million. Do you have any important control over that, or coordination of that?

Dr. DOWDLE. There is input in several different ways I think Dr. Fauci may have explained that they have coordination through

NIH and some of their programs. In fact, there are also other PHS agencies on their review committees for the research program.

Mr. **Early**. But Doctor, $55.1 million is for testing for all the services. $40 million was provided to the Army for research, with the directive that the Army's research activities be coordinated with NIH and other agencies engaged in the AIDS research. Why wouldn't the argument or the suggestion of what we are doing with NIH and other agencies be fitting for the defense monies also?

Dr. **Dowdle**. It would be.

Mr. **Early**. It would be.

NEED FOR ADDITIONAL AIDS RESOURCES

Doctor, since you requested what I describe as broad authority, do you anticipate that you would need any additional money for the AIDS effort?

Dr. **Macdonald**. The answer is, we don't know. We have asked for an additional $20.3 million in the 1987 budget. We are not sure what way we are going to go with vaccines and anti-viral agents and enhancers. That is a possibility for increased needs. I think that is what that one percent figure is there for.

Mr. **Early**. In your justification, do you have the authority under this particular recommendation to give the money to CDC?

Dr. **Macdonald**. The answer is yes.

Mr. **Early**. Well, like on page 61, priority disease control and research, PHS Action, Section 301, I thought 301 or the authority applied to NIH.

Mr. **Forbush**. Any agency in the Public Health Service can use Section 301 if it is appropriate.

Mr. **Early**. Thank you, Mr. Chairman.

Mr. **Natcher**. Mr. Conte.

Mr. **Conte**. Thank you, Mr. Chairman.

Dr. Macdonald, it is always good to see you, and it is always good to see a Williams College graduate make good. You have been doing an excellent job, both with ADAMHA and as Acting PHS Assistant Secretary. We are proud of your record.

Dr. **Macdonald**. Thank you, sir.

Mr. **Conte**. I look forward to working with you in the months ahead.

AIDS COORDINATOR

First of all, I want to take this opportunity to commend you for the appointment of the AIDS coordinator. I think it was fundamentally a sound decision to set up someone in a formal kind of a structure to set out a plan of action to use the funding resources as rationally as possible. Prior to that I thought it was each agency scrambling for as big a piece of the pie as they could get, and outside groups pushing for more money without anyone to turn to in the department to evaluate all of this and from an overall perspective to see what needed to be done and what made sense and what didn't make sense.

The success of the Coordinator would depend upon the credibility that could be established, and from my perspective that credibility will depend upon the Coordinator's ability to speak his mind on what resources are necessary.

From your perspective, Doctor, will the Coordinator have the independence to be able to provide a scientific and non-political outlook as to what is required to mount this coordinated, full-speed attack on the AIDS epidemic?

Dr. MACDONALD. I thank you for your comments about the AIDS Coordinator. I would agree, it is a major step forward. He is not, however, a czar. The function that is filled by the AIDS Coordinator was previously a part of the function of the Assistant Secretary for Health. Through the administrations of Dr. Brandt and Dr. Mason, the Assistant Secretary for Health was de facto the AIDS Coordinator.

Dr. Dowdle is on board now as a person who works for the Assistant Secretary for Health, reports to the Assistant Secretary for Health, and acts as his main person in coordinating activities. What Dr. Dowdle does is always subject, however, to the privilege of the Secretary. It really hasn't changed in regard to how the Coordinator can function.

What he does offer that was not previously there is the day-to-day expertise that he brings to the case, the time he spends, and in the case of Dr. Dowdle, the great credibility he has in the science field. The scientists know Dr. Dowdle, trust and respect him, and know that he will fight for what he thinks is right. Dr. Dowdle is not a political figure, never has been and, hopefully, will not be.

Mr. CONTE. Well, from the Administration's standpoint, it would also seem to me to be beneficial to remove all doubts about its commitment, overcoming what, by its own statements, is a top public health problem facing the nation by providing that independence to be able to state what is needed and when it is needed.

SURGEON GENERAL'S STUDY ON AIDS

Let me ask you this: What relationship does this effort to set up a coordinated AIDS effort in the Department have with the President's request for a study to be done by the Surgeon General?

Dr. MACDONALD. I guess it has some. I would suspect that the reason for the President's request to use the Surgeon General is, despite the fact that you and I like the idea of an AIDS Coordinator, the majority of the people in this country know who the Surgeon General is and respect the title of that office. When they hear pronouncements from the Surgeon General, it will have considerably more significance in alleviating the panic and what has been called the "epidemic of fear" relating to AIDS than if Dr. Dowdle or I were to do it.

Dr. Koop is now working on that report and has three people working for him full-time. He is in daily or close to daily contact with Dr. Dowdle in terms of content and what the final product will be. The report will be something that bears the stamp of the Coordinator and the Assistant Secretary for Health.

AIDS COORDINATION PLAN

Mr. **Conte**. In both the House report and the conference report accompanying the FY '86 Appropriations Bill, we asked that a coordinated plan be devised and submitted to the committee.

Can you submit that plan to the committee at this point?

Dr. **Macdonald**. Yes, sir. We have such a plan and can indeed submit it. You're talking about the AIDS coordinating plan?

Mr. **Conte**. Yes.

Dr. **Macdonald**. As different from the AIDS strategy that we've put together? I don't know that we have anything that has been specifically spelled out in writing.

Mr. **Conte**. You proposed that plan about August of last year, a coordinated plan. Have you done any more since then? Is there a plan that we could look at?

Dr. **Dowdle**. Yes. In fact, there is a Public Health Service Plan for Prevention and Control of AIDS which was published in September of last year. The plan will be reviewed again in June of this coming year, and we will look at it in terms of trying to project what will be happening five years down the road and also what sort of mid-course corrections are needed at this present time.

This review, I might say, is also sort of the beginning of the foundations of the budget for 1988, as well as refining for 1987.

Yes, sir, the report can be provided.

Mr. **Conte**. Also include those reports that were requested in the Committee reports and Conference report.

[Information to be furnished follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service
Office of the Assistant Secretary
for Health
Washington DC 20201

NOV 8 1985

Mr. Henry A. Neil
Staff Director
Subcommittee on Labor-Health and
Human Services-Education
Committee on Appropriations
House of Representatives
Washington D.C. 20515

Dear Mr. Neil:

In our meeting on November 5, to discuss AIDS resource issues, concern was raised regarding the coordination of AIDS efforts. You had asked that I provide you with a description of how the Public Health Service (PHS) coordinates the Acquired Immune Deficiency Syndrome (AIDS) issue.

The Assistant Secretary for Health (ASH) is responsible for all AIDS activities within the PHS, and management is carried out on a daily basis through the existing line authorities. However, as the issues associated with AIDS have increased in number, so has the need to augment line management with additional coordination mechanisms. For example, the PHS Task Force on AIDS was established by Dr. Edward Brandt, the former ASH in July of 1984. During this past month, we have formally documented this process, as well as implemented several changes, and I have enclosed a copy of the COORDINATION PLAN FOR AIDS ACTIVITIES WITHIN THE PHS for your information.

The coordination plan identifies four integrated components:

- The AIDS POLICY BOARD is comprised of the ASH, the Surgeon General, the Senior Advisor for Environmental Affairs, and the PHS agency heads. It meets at least bimonthly to review performance, to anticipate future issues, and to discuss new directions with respect to policy and resources.
- The EXECUTIVE TASK FORCE ON AIDS is chaired by the ASH and membership includes the Working Group chairpersons, the agency AIDS Coordinators, agency heads, and other staff. The Executive Task Force meets on alternate

Mondays and provides a forum for issues discussion, coordination of various issues, information sharing, and consensus building.

- The WORKING GROUPS meet at least monthly, are chaired by senior PHS officials and scientists, and include membership from appropriate PHS agencies and staff offices. They are intended to provide cross agency coordination, to develop products on issues assigned by the ASH or Executive Task Force, and to identify gaps in coordination in areas of their concern. The five Working Groups are as follows:

  -- VACCINE DEVELOPMENT AND THERAPEUTIC INTERVENTION,

  -- EPIDEMIOLOGY AND PREVENTION,

  -- BLOOD AND BLOOD PRODUCTS,

  -- PSYCHOLOGICAL, PSYCHIATRIC, AND ADDICTION ASPECTS, and

  -- INFORMATION.

- AGENCY AIDS COORDINATORS report to the agency head and are responsible for coordination of AIDS issues within the agency.

I believe that this current approach is both efficient and effective. It provides the ASH and agency heads with the management authority, as well as the information and discussion forums necessary to direct the AIDS issue within the PHS.

I have also enclosed for your information a copy of the outline for the PHS Plan for Prevention and Control of AIDS. This document, which was recently published in PHS Reports, describes the key goals and objectives that must be met to achieve Prevention and Control of AIDS.

I hope this information will be helpful. If you have further questions, please do not hesitate to contact me or my staff.

Sincerely yours,

James O. Mason

James O. Mason, M.D., Dr.P.H.
Acting Assistant Secretary for Health

2 Enclosures

COORDINATION PLAN FOR AIDS ACTIVITIES WITHIN THE PUBLIC HEALTH SERVICE

THE FOLLOWING REPRESENTS A COORDINATION SCHEME. IT IN NO WAY ALTERS OR MODIFIES SUBSTANTIVE AREAS OF RESPONSIBILITY.

I. ASSUMPTIONS

A. AIDS will remain a top priority of the Department.

B. The level of activity associated with AIDS--both as to numbers of issues and the number of individuals/organizations involved--will grow over the future.

C. The AIDS issue will remain one that crosscuts PHS agency lines.

D. The Assistant Secretary for Health (ASH) will remain as the focal point for AIDS within the Department.

E. The current approach to the management and coordination of AIDS within the PHS will need modification over time to accommodate the anticipated growth.

II. OBJECTIVES

A. To ensure that there is efficient coordination of the AIDS activity to keep pace with the increasing number of issues and that relevant PHS and other organizations are appropriately aware of issues and information..

B. To provide the opportunity and environment for PHS decisionmakers to anticipate and address new issues and future areas of concern as well as identify gaps, redundancies, and conflicts in AIDS activities and to resolve those situations.

C. To supply ASH and agency heads with appropriate /accurate/timely information needed to make decisions and to maximize the effective use of their time.

D. To ensure that all official PHS documents are available in a timely fashion to be reviewed for soundness and approved by the ASH.

III. ORGANIZATION/STRUCTURE

Management

A. The ASH is responsible for all AIDS activities within the PHS. The Senior Advisor on Environmental Affairs provides specialized and intensive support on issues of specific concern to the ASH.

B. Agency/Center heads are responsible for all AIDS activities within their agency.

Coordination

C. AIDS Policy Board to be composed of the ASH, the Surgeon General, the Senior Advisor for Environmental Affairs, and the agency heads. Others may be asked to attend by the ASH on an as-needed basis. Meets no less often than bimonthly to review performance, anticipate future issues, and discuss new directions with respect to policy and resources, including assisting the ASH in setting directions for the Executive Task Force and Working Groups. The Policy Board's basic mission is to assist the ASH in carrying out his overall management responsibility for AIDS.

D. Executive Task Force on AIDS continues to provide forum for issue discussion, coordination of various issues, information sharing and consensus building. The chairman can make assignments to the Working Groups as appropriate. The Task Force continues to meet on alternate Mondays and would be attended by senior officials (agency coordinator and working group chair, agency head is invited but need not attend). The ASH will continue to chair this meeting unless he delegates it to the Senior Advisor for Enviromental Affairs.

E. Working Groups meet at the call of the chair but at least monthly and are chaired by senior PHS officials. To provide cross agency coordination and to develop products on issues assigned by the ASH or the Executive Task Force, and to identify gaps in coordination in areas of their concern. The working groups are as follows:

-- Vaccine Development and Therapeutic Intervention (NIH);

-- Epidemiology and Prevention (CDC);

-- Blood and Blood Products (FDA);

-- Psychological, Psychiatric, and Addiction Aspects (ADAMHA); and

-- Information (Office of Public Affairs).

IV. RESPONSIBILITIES

The following specific responsibilities are identified through this document. Those responsibilities related primarily to management are designated by (M) and those related primarily to coordination designated by (C).

A. ASH

1. Ultimate responsibility for all aspects of AIDS. (M&C)

2. To chair biweekly Executive Task Force meetings or delegate to the Senior Advisor on Environmental Affairs. (C)

3. To chair bimonthly (may meet more often) Policy Board meetings. (C)

4. To review and approve all policy documents intended for the Office of the Secretary or the public. This review will consider the concerns and recomendations of the agency heads and Executive Task Force members as appropriate. (M)

5. To be principal spokesperson for PHS on AIDS. (M)

B. AGENCY HEADS

1. Direction/coordination of all AIDS activity in his/her agency. (M)

2. To identify a senior official to coordinate all agency AIDS activity (Agency Coordinator). (M)

3. To ensure that all information/assignments regarding AIDS in the agency is of high quality and sent forward to ASH on a timely basis. (M)

4. To participate in Policy Board meetings to review overall issues-gaps, new directions, problems, etc. (C)

5. To identify a senior official to chair the agency's Working Group responsibilities (note that OPA chairs the Information Working Group) and ensure that this individual accurately reflects the agency position in Working Group activities. (M).

6. To identify individuals to represent the agency on those working groups which the agency does not chair, and to ensure that these individuals accurately reflect the agency position in working group activities. (M)

7. To be responsible for and direct the development of the semi-annual review of all R&D activities within the agency to be presented to the ASH, and the Policy Board/ Executive Task Force. (M)

8. To ensure that biweekly status reports of agency assignments are sent forward to ASH. (M)

C. WORKING GROUP CHAIRPERSON (C)

1. To prepare agenda and chair Working Group meetings on an as-needed basis but no less often than monthly.

2. To assign tasks to working group members, track progress on these tasks, and to report to the ASH and the Executive Task Force on the working group's activities.

3. To coordinate issues within the Working Group's purview, including identifying gaps and overlaps and undertaking appropriate activities to resolve any problems caused by them.

4. To undertake assignments made by the ASH or the Executive Task Force and report back to the same within the timeframes requested.

5. To develop a short summary of the meetings--to include a list of all action items--and send them to PHS Executive Secretariat by COB Wednesday following the meeting for use of the ASH and the Executive Task Force.

D. SENIOR ADVISOR ON ENVIRONMENTAL AFFAIRS

1. To undertake special assignments as directed by the ASH. (C&M)

2. To serve as a member of the Policy Board and to prepare a list of all action items identified in those meetings (this list will be sent to the Executive Task Force members). (C)

3. To chair the biweekly Executive Task Force meeting when so directed by the ASH. (C)

E. AIDS AGENCY COORDINATOR (C)

1. To review key policy documents for accuracy, consistency, and clarity. Identify problems and gaps/overlaps in agency activities (this would include agency Working Group members' issues). When necessary, recommend appropriate course of action to agency head.

2. To prepare on a biweekly basis a status report for the agency head on all agency assignments. (this will in turn be sent to the ASH on Thursdays prior to Executive Task Force meetings). The report will emphasize areas where the activity has fallen behind and recommend courses of action to get it back on track.

3. To assist in the development of the semi-annual R&D reviews.

4. To forward to the agency head and then to the ASH, agenda items and any written documents for Executive Task Force meetings on the Tuesday preceding the meeting.

ARTICLES—POLICY

Public Health Service Plan for the Prevention and Control of Acquired Immune Deficiency Syndrome (AIDS)

Foreword

The PHS Executive Task Force on AIDS has developed this framework within which the Public Health Service is working to control and prevent acquired immune deficiency syndrome (AIDS) by the year 2,000. Our comprehensive plan is based on the state of the art since the isolation of the human T Lymphotropic Virus-III and development of the blood test to detect evidence of infection by the virus.

The plan includes broad-scale information and education activities in addition to research efforts to develop a vaccine, and treatments to fight the AIDS virus and restore functioning of the immune system.

Within each of these areas the PHS agencies have developed comprehensive plans of action. Programs to effect behavior changes for persons at risk and provision of up-to-date information on AIDS are important features of the plan, which assumes that a vaccine and effective therapy may not be immediately available. This outline and the specific plans of action are dynamic—as new information becomes available, steps will be modified accordingly.

The plan was developed as a continuation of the Public Health Service's extraordinary efforts to deal with this tragic disease almost since the first cases were reported in 1981.

James O. Mason, MD, DrPH
Acting Assistant Secretary for Health

PURPOSE

This document provides an outline for the key goals and objectives that must be met to achieve prevention and control of AIDS. The plan calls for action by Federal agencies, State and local health departments, professional organizations, and volunteer groups. Many of the specific objectives cannot be expressed in measurable terms because of inadequate current information, but they are included here even though modifications will be made as more data are generated.

I PROBLEM

A AIDS is a very serious, often fatal, disease caused by the virus HTLV-III.

B The incidence of AIDS and infection with HTLV-III is increasing steadily in the United States.

C More persons are known to be infected with HTLV-III than have become ill. The incubation period for AIDS in adults may range from 1 to 6 years or more and in infants from 6 months to 5 years or more.

D Infected persons may be capable of transmitting infection for many years, even though they may remain asymptomatic.

E The ability of HTLV-III to persist in the infected individual results in a population of persons who may be at risk for years for development of severe illness.

F HTLV-III infection is transmitted by infected sexual partners through exchange of body fluids, through equipment used to administer intravenous drugs of abuse, through contaminated blood and blood products, and from infected mothers to infants. Members of all population groups thus exposed are at risk.

G No effective vaccine or therapy exists.

II ASSUMPTIONS

A A person with a repeatedly reactive HTLV-III antibody test is infected with HTLV-III and able to transmit the virus to others.

B Psychosocial and medical problems will increase as the number of AIDS cases grows and HTLV-III infection spreads.

C The more HTLV-III infection is disseminated throughout the population before effective control measures begin, the harder it will be to bring it under control.

D Because there is no means of intervention during the long incubation period to prevent severe AIDS, a vaccine that prevents infection will be an effective tool for control only after it has been in use for several years. On the other hand if early therapy becomes available to reduce infectiousness in those already infected, and if persons at risk take responsible preventive measures, control of AIDS will be realized much sooner.

E It is unlikely that a vaccine or therapy to substantially limit transmission will be generally available before 1990.

F Broad scale prevention and control activities, emphasizing educational and information exchange, must begin in the absence of available vaccine and specific therapy. They should be based on current best public health judgment.

G Demonstration and evaluation projects are needed to determine the efficacy and cost-effectiveness of prevention and control strategies.

III GOALS

A By 1987, reduce increase in transmission of HTLV-III infection.

B. By 1990, reduce increase in the incidence of AIDS.

C. By 2,000 eliminate transmission of HTLV-III infection with a decline in the incidence of AIDS thereafter.

IV. OBJECTIVES

A. Continue to clarify the epidemiology and natural history of HTLV-III infection.

  1. Maintain current epidemiologic surveillance of AIDS cases in the United States.
  2. Monitor the incidence of HTLV-III infection by geographic areas and among major high-incidence groups.
  3. Define diagnostic criteria for AIDS and other conditions associated with HTLV-III infection.
  4. Evaluate the usefulness of surveillance of other AIDS-related conditions.
  5. Determine
     a. How frequently and under what circumstances HTLV-III infection persists in an infected individual.
     b. The efficiency of virus transmission by route of exposure, magnitude of exposure (dose), and other conditions.
     c. The severity of disease in relation to time and source of infection.
     d. The time frames for development of antigens and antibodies to HTLV-III in blood of infected individuals.
     e. The role of host factors and cofactors, including interaction with other organisms, in disease risk.
  6. Develop and evaluate new diagnostic tests for HTLV-III and improve existing assays.
  7. In order to clarify risk factors and protective factors for HTLV-III infection and AIDS, conduct epidemiologic investigations in various groups including
     a. Homosexual/bisexual men
     b. IV drug users.
     c. Persons with hemophilia
     d. Recipients of units of blood or blood components containing HTLV-III.
     e. Both seropositive pregnant women to determine pregnancy outcome and the infants born to them.
     f. Heterosexual partners of infected individuals or of those at risk (e.g., prostitutes)
     g. Members of households of infected individuals
     h. Health care, dental, and laboratory workers
     i. Populations in countries where AIDS becomes prevalent

B. Continue to implement national, State, and community risk reduction and education programs as early prevention and control measures.

  1. Provide current information on AIDS to all segments of the American public. Special efforts will be made for
     a. Individuals at increased risk for AIDS to effect behavior change, which currently is the only mechanism available to prevent infection.
     b. Health care providers to increase diagnostic, treatment, and counseling services.
     c. Researchers to increase dissemination of their findings to speed the development of vaccine, therapy, and other intervention measures.
     d. Other groups including unions, management, blood collection agencies, high-risk group organizations, and educational authorities to disseminate accurate information to those who may have a responsibility for persons with HTLV-III infection.
  2. Develop specific prevention and control recommendations through consensus building among key individuals and groups.
     a. Convene representatives of relevant groups and organizations to generate specific recommendations for the control of AIDS among the following groups at high risk
        (1) Homosexual and bisexual men, including representatives of black and Hispanic groups
        (2) IV drug users
        (3) Heterosexual persons with multiple sex partners.
        (4) Female partners of men at high risk, with special emphasis on perinatal transmissions
        (5) Haitians and central African entrants to the United States
        (6) Recipients of blood and blood products, organs, and tissues and artificially inseminated women.
     b. Convene representatives of State and local government agencies and professional and community groups concerned with research, the provision of care, educational aspects, and psychological aspects of AIDS to assist in coordinating appropriate programs.
  3. Encourage the implementation of community risk reduction and health education programs to effect behavior change regarding high-risk sexual practices and the use of IV drugs.
     Strong efforts will be especially useful in those geographic areas where high-risk groups do not have high rates of infection.
     a. Provide targeted education for groups and individuals at risk regarding specific high-risk behaviors.
     b. Provide risk reduction programs for high-risk groups and individuals to enable them to make the needed changes in their behaviors.
  4. Provide medical referral and counseling programs to persons who request testing or who know their antibody status as a result of blood or plasma donations.
  5. Continue to reduce opportunities for virus transmission through blood and blood products.
     a. Encourage voluntary donor deferral.
     b. Screen all units of blood and plasma.
     c. Require donor deferral lists for persons with reactive tests.
     d. Inactivate HTLV-III in all blood components and products where feasible.
  6. Encourage testing for donors of organs, tissues, cells, and semen for antibody to HTLV-III.
  7. Reduce opportunities for virus transmission through environmental measures.
     a. Encourage hospital and laboratory personnel to follow recommended precautions with patients or specimens known or suspected to be HTLV-III positive.
     b. Use effective disinfectants on contaminated equipment.

c. Encourage proper personal hygiene among infected persons.

C. Design and evaluate improved prevention and control measures.

1. Develop and evaluate better approaches for detecting infection.

a. Determine antigenic, genetic, and other variation among HTLV-III isolates.

b. Develop and evaluate new antigen tests.

c. Cooperatively develop guidelines for use of currently available and new tests.

2. Develop and evaluate active immunoprophylaxis.

a. Convene scientific advisory committees to plan for development and evaluation of vaccines.

b. Characterize HTLV-III antigens biochemically and structurally to determine the specific component parts of the virus against which the antibodies generated by a vaccine would react.

c. Develop specific candidate vaccines including subunit products, synthetic peptides, genetically synthesized antigens, and others.

d. Develop new means of preparing, packaging, preserving, and transporting vaccine.

e. Develop new, effective methods for delivering vaccine to substantial numbers of people.

3. Develop and evaluate passive immunophylaxis, using artificially prolonged antibody.

4. Develop and evaluate drug and biologic therapy including antivirals, immune stimulants, and combinations of these.

a. Evaluate existing candidate compounds in laboratory systems and clinical trials.

b. Design, produce, and evaluate new drugs based on results with existing compounds.

c. Develop new immune stimulants and test available stimulants in animals or clinical research objects, investigate reconstitution of immune system, e.g., bone marrow transplantation.

d. Test immune stimulants combined with antiviral therapy against HTLV-III.

e. Evaluate host factors and possible cofactors.

5. Develop and improve animal models to accomplish studies that cannot be done with humans or *in vitro* systems.

a. Test candidate vaccines and drugs in chimpanzee and rhesus monkeys, which are the only animals shown thus far to be infected with HTLV-III.

b. Use existing animal models and seek new species for study of animal retroviruses related to HTLV-III, e.g., feline leukemia in cats and retrovirus infection in nonhuman primates. Study agents that control these viruses.

6. Assure that adequate facilities exist to support studies in the development and evaluation of vaccines, antivirals, and immune stimulants listed above.

D. Design and promote prevention and control programs that will enhance effectiveness by incorporating new intervention tools (vaccines antivirals) as they become available.

Mr. **Conte**. We called for the Coordinator to keep the Committee apprised on a regular basis as to the progress in developing and implementing the national, coordinated response and strategy for AIDS.

Can you tell us what you've done or what you will do to comply with that requirement?

Dr. **Macdonald**. I will have Dr. Dowdle comment. One of the things I thought Dr. Mason did very effectively was to have conferences with Congressional staff and Congressional people on a regular basis to bring you up to speed on what was happening. We continue to think that those are worth doing.

Mr. **Conte**. Is there any more that you could say to bring us up to date?

Mr. **Little**. Mr. Conte, you also included in the report a request that NIH provide a plan on how it would use the $70 million that the committee had appropriated. That report was provided to the Committee. It describes in detail how those funds would be used. I think that we understood that this report would satisfy the major part of your request.

CONSOLIDATION OF FUNDING

Mr. **Conte**. Now that we have got the funding going, I would certainly be willing to support whatever your coordinated plan would require in terms of funding, but I do not particularly see the wisdom of putting all the funds into a pool and taking them out of their operational division, since after all, the funds would go right back into the operational division. After all, that resource allocation is one of the few ways we have to track the AIDS effort.

What would you get from putting all the funds into one pool that you don't get now?

Dr. **Macdonald**. Flexibility, a chance to change if we need to. Our plans in 1987 are to spend the funds as developed by the agencies in conjunction with the Assistant Secretary prior to the plan to consolidate. In 1987, we see the funds going out by the old process.

It will strengthen the role of the Coordinator in terms of the importance he has. We see that role as one of highlighting, planning, and coordinating AIDS activities out of that office. It also supplies some small amount of funds for his function.

Mr. **Conte**. Well, you seem to have flexibility. I would certainly warn that you still have to make the case that we have not been responsive to allocating funds where they are needed. I'll be looking at that very closely.

Why hasn't FDA been included in the coordination at the Assistant Secretary's level?

Dr. **Macdonald**. They will be coordinated with, but that's a different committee, as you know. They come out of the Agriculture Committee. That's a separate appropriation of a little under $10 million.

TITLE X REGULATIONS

Mr. **Conte**. I see.

With regard to Title X, are you planning any revision or change in any regulations or guidelines?

Dr. **Macdonald**. JoAnn Gasper is with me, and I might have her respond to that, but the answer is, no, we are not. We are looking at Title X regularly, but see no change that we are ready to run forward now.

JoAnn Gasper is the Deputy Assistant Secretary for Population Affairs and is responsible for the administration of Title X and the of Title XX.

Mr. **Conte**. You take Mrs. Mecklenberg's place?

Ms. **Gasper**. Yes. I took Mrs. Mecklenberg's place I guess a little bit over a year ago, and I am delighted to be able to come back and meet with you again.

We, of course, will continually look at how to improve Title X as long as it continues to be a categorical program. We do not have any changes in regulations or guidelines in the clearance process at this time.

Mr. **Conte**. Mrs. Gasper, is the funding of abortion a permissible activity under Title X?

Ms. **Gasper**. No, sir. It is prohibited to fund abortion services under Title X. Our legislation specifically prohibits the use of abortion as a method of family planning.

Mr. **Conte**. Is the encouragement of promotion of abortion a permissible activity under Title X?

Ms. **Gasper**. No, our grantees are not supposed to be encouraging or promoting abortion under the program.

Mr. **Conte**. Are you familiar with the Kemp Amendment?

Ms. **Gasper**. Yes, sir, I am.

Mr. **Conte**. Would that have permitted abortion if the life of the mother was in danger?

Ms. **Gasper**. I want to make sure I am correct on the Kemp Amendment. I assume you're referring to——

Mr. **Conte**. The one that was defeated last year.

KEMP-HATCH AMENDMENT

Ms. **Gasper**. The Kemp-Hatch Amendment would have prohibited our grantees to counsel or refer for abortion services or for us to fund organizations that promoted abortion. There were several different versions that were discussed.

Mr. **Conte**. Well, I'll read his language here.

> On page 5, line 13, add the following: Provided none of the funds appropriated out of this Paragraph (1) may be used to provide to any pregnant woman abortion procedures or referral for abortion procedures unless the life of such woman would be endangered by carrying the fetus to term.

Wouldn't that, for the first time, have allowed abortions under Title X?

Ms. **Gasper**. No, sir. I believe that the language speaks to counseling and referral for abortion.

Mr. **Conte**. Let me repeat, "To provide to any pregnant woman . . . unless the life of such a woman would be endangered by carrying the fetus to term."

Ms. **Gasper**. Presently under the program, there can be counseling and referral for abortion services.

Mr. Conte. I realize that, but this says that "none of the funds appropriated under this Paragraph (1) may be used to provide to any pregnant woman abortion procedures or referral for abortion procedures unless the life of such woman would be endangered by carrying the fetus to term." And I am only asking you the question, if that had been adopted, for the first time under Title X, would that have allowed an abortion where the life of the mother was endangered?

Ms. Gasper. No, that is not my understanding of the amendment. It would have prohibited referral unless the mother's life was in danger. Presently under Title X, under the guidelines for Title X, if a woman has an unintended pregnancy and requests information, she is supposed to be given her options, and her options include prenatal care, in other words carrying the baby to term, adoption as a possible option, and pregnancy termination or abortion. And she may, under Title X as currently operated under our guidelines, be provided referral and counseling regarding pregnancy termination. There is no restriction regarding whether or not her life is in danger.

Mr. Conte. I understand the present law. I'm only saying that if this language was adopted, for the first time under Title X, abortion would be allowed where the life of the mother was endangered.

Ms. Gasper. I'm not a lawyer. But it's my understanding that it would not permit abortion services in Title X, and that it would restrict the abortion counseling and referral to only situations in which the mother's life was in danger.

Dr. Macdonald. As I read that, Mr. Conte, and I heard you read it, it seemed like that was less pro-abortion than the previous one. What Ms. Gasper says is that the present law says that you can, as an option, refer for abortion, period. This restricts it to say that you can refer for abortion providing the mother's life is in danger and would restrict other abortion referrals, but it does not provide the service.

Ms. Gasper. Yes. The language prohibits a procedure which we don't do anyway.

Mr. Conte. That's exactly right. I'm just saying that under the present law, under Title X, you cannot allow abortions. But if this language were adopted, it would have allowed abortions when the life of the mother was endangered.

Ms. Gasper. I would have to request legal counsel.

Mr. Conte. Well, the language is very clear. Go ahead and have your legal counsel send me an opinion on that.

Ms. Gasper. We will ask our lawyers to look at it.

[Information to be furnished follows:]

KEMP-HATCH AMENDMENT

The Kemp amendment is consistent with the purposes of the Title X program, the Administration's opposition to abortion, and current limits on the use of Federal funds to pay for abortions.

Since the program was established in 1970, section 1008 of Title X has prohibited the use of Title X funds in programs where abortion is a method of family planning. In addition, based on congressional intent, program policy has prohibited projects from using Title X funds to encourage or promote abortion as a method of family planning. Although provision of abortion for medical reasons falls outside the scope of the Title X abortion prohibition, the Hyde amendment restriction on Federal funding of abortion procedures would apply. Therefore, the only allowable Title X funding of medically indicated abortions would be limited to cases where the mother's life would be endangered if the pregnancy were carried to term. The Kemp amendment exception allowing provision of abortion only in "life of the mother cases" recognizes the same exception allowed in the Title X program under the section 1008 restrictions and the Hyde amendment restrictions on Federal funding of abortion.

Title X program policy has recognized that when referral for abortion services is necessary because of medical indications, abortion is not considered as a method of family planning, but rather a medical treatment required by the patient's condition. As such, referral for provision of abortion for medical reasons would not come within the scope of the Title X abortion prohibition. Since the Hyde amendment would not reach a matter of abortion, the Kemp amendment would serve to further limit the circumstances under which referral for abortion could be made with Title X funds. The Kemp amendment would accomplish this by restricting abortion referral to situations in which the mother's life would be endangered by carrying the fetus to term.

However, since Title X is a family planning program rather than a program intended to provide emergency care, provision of medically indicated abortions, even as permitted in some cases by the Hyde amendment and the section 1008 language, would still be quite rare. Since the purpose of the Title X program is to provide family planning services and grantees are explicitly prohibited from providing abortion as a method of family planning, grantees would not be prepared or equipped to handle abortion procedures. Nevertheless, under both the current law and the proposed Kemp amendment, projects would not be violating the Title X abortion restriction if they referred for, or provided, abortions which were medically indicated as necessary to save the life of the mother.

Dr. **Macdonald**. But didn't Ms. Gasper say that under the present law you can refer for abortion?

Ms. **Gasper**. That's correct. In other words, this language would be more restrictive than our current operation of the program vis-a-vis our abortion counseling and referral activities.

Again, I say I am not a lawyer, so I would have to have a lawyer——

Mr. **Conte**. Under the present law, you cannot provide abortions.

Ms. **Gasper**. We cannot provide abortions.

Dr. **Macdonald**. Nor under this.

Ms. **Gasper**. Nor under this.

Dr. **Macdonald**. Nor under this. They're both talking about referral. They're talking about referral.

Mr. **Conte**. No. Go ahead and read that language. That language is as clear as a bell. It says "provide or refer."

Ms. **Gasper**. The amendment prohibits provision, but there is nothing that permits us—there is nothing in our statute which permits us to provide abortion services anyway. We are prohibited under current statute from using abortion as a method of family planning.

We are also part of the Public Health Service, which operates under the Hyde Amendment language which restricts abortion services.

Mr. **Conte**. And under Medicaid?

Ms. **Gasper**. It is my understanding that the Hyde Amendment impacts on all on all HHS-funded programs.

Mr. **Conte**. Well, Mr. Natcher and I were part of the Hyde Amendment. But on this one here, your counsel, I think, will agree with me. Everyone else agreed with me, every lawyer I talked to agreed with me, that under this language.

Title X would have been changed and would have provided for abortion where the life of the mother was endangered. That's all I'm saying.

Ms. GASPER. I will review this with our legal counsel and provide an answer to you.

Dr. MACDONALD. I read it the same as you do.

Mr. NATCHER. Mr. Stokes, before yielding to you, I want to welcome the former mayor of Dayton, Ohio, Mr. James McGee and Mrs. McGee, in the committee room and to say to you folks that we are glad to have you. It's a distinct honor and a privilege for me to serve on this committee with my friend, Lou Stokes.

A long time ago, we had a member of our committee—his name was Mike Kirwan; he was from Youngstown, Ohio—and he used to test the members to see if they were either for him or against him. And he would say, "He tests well," if it was all right with Mike Kirwan. My friend, Lou Stokes, always tests well.

Lou, I yield to you.

Mr. STOKES. Thank you very much, Mr. Chairman. It's very kind of you to say that. Thank you.

OFFICE OF MINORITY HEALTH FUNDING

Dr. Macdonald, just prior to leaving office, former Secretary Heckler set up a new Office of Minority Health within the Office of the Assistant Secretary for Health. Dr. Bowen, as you know, has appointed Dr. Herbert Nickens to administer that office.

Now I've read your budget justifications. I find no reference whatsoever to that office. What is the reason for this?

Dr. MACDONALD. I will ask one of my supporting witnesses to answer that question. But we are prepared to spend $2 million from the PHS budget for Dr. Nickens' office.

Mr. FORBUSH. Mr. Stokes, the decision to establish the office was made after the budget for the Office of the Assistant Secretary was completed. The activities for fiscal 1986 and 1987 will be funded by means of assessments on programs that deal in this general area, and we have made these funds available by making such assessments. It is a collaborative effort across PHS and HHS in general.

Mr. STOKES. That accounts for the fact that no reference is made in your budget request?

Mr. FORBUSH. That is why it does not appear in the 1987 budget. We would hope that when we prepare our fiscal 1988 budget, that there will be a specific line item for Minority Health at that time.

Mr. STOKES. What accounts for the difference between the $3 million Dr. Bowen told us about and the $2 million you mentioned?

Mr. FORBUSH. The original plan, when the office was approved, was that $2 million of the $3 million would be provided by the Public Health Service and the other $1 million would be assessed from programs outside of PHS. That was the original plan for financing the $3 million.

Mr. STOKES. Under the current plan, will the office be funded at $2 million or $3 million?

Mr. FORBUSH. At the present time PHS has provided $2 million. If funding requirements exceed that amount, we will work with the Office of the Secretary to increase the amounts available.

Mr. **Stokes**. I notice that you have at the table the AIDS Coordinator. Why do you not have the person coordinating the Office of Minority Health here?

Dr. **Macdonald**. Dr. Nickens is here with us. He is not at the table because we thought we were going to get more questions in Dr. Dowdle's area than in Dr. Nickens' area. Dr. Nickens, would you please join us?

Mr. **Stokes**. Thank you. It is nice to have Dr. Nickens here. Tell us what your plans are for this office with regard to both funding and staffing?

Dr. **Macdonald**. Dr. Nickens, do you want to tell us what you discovered in your brief tenure?

STATUS OF THE OFFICE OF MINORITY HEALTH

Dr. **Nickens**. Well, most of the eight weeks that I have been on board I have been trying to organize the office and that has taken up a great deal of energy and time. At the same time, I have begun to go after the seven elements that are listed in the mission's statement in the Federal Register. There were actually nine, but seven components. I have been surveying the country looking for model programs and also spending a great deal of time in outreach, trying to contact groups that are interested in minority health and are doing activities interested in organizing activities. That includes community groups and also medical groups and so forth.

We have also been sponsoring conferences in various states and localities. Several of those have already happened and there are also several planned for the future.

In addition to that, I have also been working with various parts of the PHS such as NIH and CDC, visiting them and talking to them about their plans to increase their activities in minority health and working on implementation plans, which is one of the elements in my office's description.

Mr. **Stokes**. What is your understanding of the funding and staffing allocated to the office?

Dr. **Nickens**. $3 million and 11 staff members.

Mr. **Stokes**. You have a tremendously important job. As we consider the task force report, which was an excellent report, it highlights the wide disparity between black and white health status in this country and it documents the fact that we are confronted with 60,000 excess deaths in the black community annually. You have a very important job and we are certainly going to monitor what is accomplished through this office.

Dr. **Nickens**. We will be working with all our efforts.

INFANT MORTALITY

Mr. **Stokes**. Thank you. Dr. Macdonald, the budget justifications indicate that about 50 percent of the 1990 national health objectives established by the Surgeon General may not be achieved by 1990. Can you tell us about the 1990 goals for black infant mortality, post-neonatal mortality, low birth rate and early prenatal care? Indicate whether these goals will be achieved by 1990.

Dr. **Macdonald**. In terms of achieving the 1990 objectives, in many respects we are doing well. But, there are some areas where we are not doing nearly as well and one of those is the one you picked—infant mortality. Our goal was to reduce infant mortality to fewer than nine infant deaths per 1,000 live births by the year 1990. According to the latest final data for 1983, the overall infant mortality rate was 11.2 in 1983. The national rate continues to decline.

However, there is, as you are aware, a great disparity in the infant death rate for black and white. For black infants in 1983, the rate was approximately 19 deaths per 1,000 live births and the white rate was running 9.7 deaths per 1,000 live births. It is a major concern to us. We have a number of areas in which we are going to spend more money and certainly more attention, in addition to what Dr. Nickens is doing.

The post-neonatal mortality rates are also higher than we would like them to be. We are not sure exactly why they are not coming down as rapidly as they should. Some of it, we feel may be related to better neonatal care so that we were keeping newborns alive for longer periods of time and they were dying in that period between one month and twelve months.

The National Center for Health Statistics is putting in additional money to look at linking birth records with death records, trying to discover if in finding out the circumstances of birth, we may get a better handle on circumstances of death. Risk factors are being looked at by CDC which is going to spend something in excess of $1.7 million more than previously, to fund two new components of the PHS infant mortality initiative.

The National Institute of Child Health and Human Development at NIH is also requesting additional funds to look at the issue of infant mortality, and within the Maternal and Child Health block grant, we are allocating funds which amount to a $5 million increase in 1987.

This is a serious problem and we are discouraged that the infant mortality rate is not coming down as rapidly as we would like it to.

1990 HEALTH OBJECTIVES

Mr. STOKES. Other than the goals about which I have asked, are there other major 1990 health objectives that may not be reached by 1990?

Dr. MACDONALD. Yes. They occur in several areas. One of the things we encountered in planning objectives was that a fair number of those objectives didn't have good baseline data. It is still difficult for us to get a handle on and we are not sure how we are doing in regard to those objectives.

Regarding the issue of nutrition, we are still waiting for survey results to see if we are doing better with that objective. Dr. McGinnis is here and perhaps would like to comment on some other objectives.

Dr. MCGINNIS. Mr. Stokes, let me make two comments, if I may. One on the broad goals that we have set to be achieved by 1990 related to life stages. The broad goals that have been set are reducing the infant mortality rate by 35 percent by 1990, reducing the child mortality rate by 20 percent, reducing adolescent/young adult mortality rate by 20 percent, reducing adult mortality rate by 25 percent by 1990, relative to 1978 baseline data when those goals were set.

For each of those areas, we are halfway or better to achieving those goals based on 1984 provisional data. We are doing quite well in the broad scheme of things.

With respect to the individual objectives, the 227 objectives necessary to be achieved in order to continue progress toward those goals, we are doing reasonably well on many of them. As you point out, there are some in which we are falling short. Based on our mid-course review of last year, our best guess is at this point that we will fall short if current trends continue, in about 25 percent of the objectives that have been stated.

In addition to the area you mentioned, that of infant mortality rates among minority populations, which is a problem, there are a variety of others in which we are falling short. One, for example, is Hepatitis B trends, which continue to increase rather than come down at the level we had hoped.

With respect to the objective related to reducing cerium cholesterol levels among the population as a whole, it looks as though we will not be able to achieve it. There are scattered throughout the objectives those which we will not be able to achieve, but in many respects, this is the purpose of the objective setting process—to point out where we need to redouble our efforts.

Mr. Stokes. Thank you, Dr. McGinnis. Thank you, Mr. Chairman.

Mr. Natcher. Mr. Hoyer.

Mr. Hoyer. Thank you very much, Mr. Chairman.

USER LIAISON PROGRAM

Dr. Macdonald, let me ask you about a specific program first, the user liaison program. I have been in touch with Dr. Marshall. Can you tell me the present status of that office as it relates to the performance of the services it was set up to perform?

Dr. Macdonald. Yes, sir. I have Dr. Marshall here with me, whom I will invite to the table to give you more clarification. The user liaison program is being modified and restructured in 1986 and the amount of money spent for this specific program is being reduced in 1986. Approximately $1.2 million was spent in 1985, our plan is now to spend $423,000 in 1986, and $175,000 in 1987.

Mr. Hoyer. $423,000 is post-Gramm-Rudman?

Dr. Macdonald. That is post-Gramm-Rudman.

Mr. Hoyer. It is $1.2 million——

Dr. Macdonald. In 1985.

Mr. Hoyer. What was the 1986 figure, pre-Gramm-Rudman?

Mr. Marshall. It would have been about $1 million or perhaps a little bit over. My plan prior to the sequestration was to reduce contract funds by $200,000 from the 1985 level. I had planned to reduce it in fiscal 1986, even absent the requirements of Gramm-Rudman.

Mr. Hoyer. By about $100,000?

Mr. Marshall. It would have been by about $200,000, because it was a little over $1.2 million in fiscal year 1985.

Mr. **Hoyer**. The 4.3 percent as applied to the $1.1 million would have been about $44,000 or $45,000; correct?

Mr. **Marshall**. If I had pursued that way of allocating the reduction that I had under Gramm-Rudman; yes, sir. If I had applied the 4.3 percent across the board to all the National Center's programs.

Mr. **Hoyer**. This is not a PPA?

Mr. **Marshall**. No, sir.

Mr. **Hoyer**. Effectively, you are eliminating the program?

Mr. **Marshall**. I don't like to think of it as eliminating it. I like to think of it as restructuring, if the object of the program is to provide dissemination of research results and to provide technical assistance to states. We are not planning to discontinue that activity. We are discontinuing one aspect of the program which was to subsidize meetings for state legislators to learn about health services research. That simply has gotten to be too expensive.

Mr. **Hoyer**. Let me ask you something about it being "too expensive." As I understand what this Administration is saying on the domestic side, it is the responsibility of us at the Federal level to pay for defense and it is the responsibility essentially of the states to pay for everything else. If that is the case, isn't it vitally important that we tell the states what is going on and what they need to do? Isn't this one of the programs that is designed to do that?

TECHNICAL ASSISTANCE TO MARYLAND

I have been contacted by some very active members of the Maryland State legislature with whom I served for many years, indicating they had participated in these programs and found them extremely helpful. As you know, Maryland has just come through over the last three years a major review of health care delivery and health care costs.

They found this program to be very helpful. Aren't we working at cross purposes?

Mr. **Marshall**. We have conducted technical assistance for the State of Maryland in two ways in the last year or 18 months. We did sponsor a workshop that was conducted under the auspices of the user liaison program. We also provided technical assistance on several occasions to the state, both to the Executive Branch and to the legislature when it was in session by sending our own staff people over to Annapolis to appear before committees or to provide analyses for the use of the committees.

We intend to continue that kind of work, Mr. Hoyer. What we will not be able to do is to continue the kind of activity that was supported, for example, under the last workshop that we did, which was a workshop that cost us $163,000 and was attended by 26 state officials. That comes out to somewhat over $6,200 per person.

Mr. **Hoyer**. That is less than each county is going to get. That is an inane analogy. Obviously, that is snipping, for which I apologize.

Mr. **Marshall**. It is on all our minds.

Mr. **Hoyer**. That is why I said it. Go ahead.

HEALTH SERVICES RESEARCH CENTERS

Mr. **Marshall**. That is a great deal of money for several days of exposure to health services research.

They are presently about 35 health services research centers in 28 of the states. What we intend to do is operate our program so that when the state comes in for information or when a state wants to have people come do a workshop, they ought to really work with the people in the state. They should work with the University of Maryland or with Johns Hopkins, both of which have this kind of capacity.

Again, our staff will continue to be available in areas where we have the expertise to send someone to Annapolis to help as we are able to.

Mr. HOYER. Doctor, that has already been effected, as I understand it, the reduction.

Mr. MARSHALL. Yes, sir. It was effected on March 1st.

Mr. HOYER. I have some more specific questions I want to ask, if you could respond to them on the record with respect to that program. Thank you very much, Dr. Marshall. My stopping questions does not necessarily mean I agree with the action you have taken but my time is limited.

Mr. MARSHALL. That is understandable.

AIDS RESEARCH EFFORTS

Mr. HOYER. Dr. Macdonald, I know you have already been asked questions but a lot of us are very concerned about what is happening with the AIDS effort in the Federal Government in terms of its centralization. Let me ask you some specific questions, if I might.

Do the funds that have been put in your office include funds for continuation of new initiatives in fiscal 1986 or does it include all AIDS research funds?

Dr. MACDONALD. If I understand the question correctly, the answer is the 1987 budget has taken full cognizance of programs and continuations. In other words, the lump sum total of the $203 million, represents those budgets that were prepared by each individual agency. As they saw continuation costs—is that your question?

Mr. HOYER. Have you consolidated all funds including those that were shifted over the last three years?

Dr. MACDONALD. This would be all the AIDS money in the Public Health Service with the exception if the FDA money that you don't see here, which is something under $10 million.

Mr. HOYER. Who is going to make the decision on the release of the money to the agencies and when will that decision be made?

Dr. MACDONALD. The decision has been made for 1987. We intend to follow the procedure where NIH will get something like $143 million, and CDC something over $45 million, and ADAMHA will get $13.7 million. In formulating the budget, we took those pieces and added them together. I think the piece that may be new is the $1.4 million which will go to the Office of the Coordinator in 1987.

The release of the money will be strictly as we release any other budget money. The agencies will plan to spend it. Any departure from that course, we realize, would be a major undertaking and is not planned at this time.

Mr. HOYER. Let's talk about the $143 million for NIH, Dr. Wyngaarden said it was his understanding that the $143 million was available and therefore they were going to proceed as if that $143 million were available to them to be applied as they see fit. Is that a correct understanding of how the decisionmaking process will work?

Dr. Macdonald. Yes, absolutely. I really understand looking for sinister redirection of money I guess you always worry about that. That is your responsibility, to look at that. I think you have to look at the players involved—the player, Walter Dowdle, the player, Jim Wyngaarden, and the player, Dr. Fauci, who sits behind us. They are all a part of this AIDS Coordinating Committee that regularly looks at the budget, looks at where AIDS is going, and where research and prevention is going.

None of us anticipate any shift from that $143 million that is going to NIH. None of us knows what the situation is going to be in September or October or whenever.

In 1985, it became apparent to the agencies and institutes involved, we were not spending enough money on AIDS. We went back to the Congress for more, and the Congress gave us that increase. The AIDS budget of $183 million that we are asking for from this Committee in 1986, is considerably above the budget of 1985, which was $100 million.

In terms of the history of the AIDS effort we have, when we thought we needed money, come back to Congress and gotten it.

Mr. Hoyer. Yes, I think both the Congress and the Administration obviously have felt that this is a crisis and has responded in terms of providing the necessary fiscal resources.

My concern is that those resources continue to be applied through avenues that this Committee has great confidence in, particularly NIH. Obviously, the biggest chunk of that goes to NIH.

Now you say nobody has any intention of redirecting funds. You are the Acting Assistant Secretary. Are you going to be there for a long period of time? Who do I have to check with to make sure you are on board, if that is your thought?

Dr. Macdonald. I am going to be there tomorrow. Obviously, the Assistant Secretary and other players change. That is a concern you might have.

SECRETARY'S POSITION ON AIDS COORDINATION

Mr. Hoyer. Would it be fair to say that this is the opinion of the Secretary, as well? Is this the position of the Secretary?

Dr. Macdonald. I think the Secretary is absolutely delighted with the creation of the position of AIDS Coordinator, likes the way the operation is going, and has faith in the Office of the Assistant Secretary.

You know the history. I cannot look to the history, as we are going to write it later, but in the past, Dr. Brandt, Dr. Mason, Dr. Dickson—all have enjoyed the confidence of this Committee and have acted very responsibly. I would anticipate that would continue.

Mr. Hoyer. You just read my focus of the question. Is it the position of the Secretary—in other words, have you discussed the application of the funds and the perception that the decisions on the application of the constituent parts would be up to the agencies involved; i.e., is NIH going to make a decision on the application of the 143 million—or will they have to make application to you. Or will ADAMHA or CDC have to make application to you for specific applications of portions of those dollars?

Dr. MACDONALD. I have not talked with the Secretary about this specifically. I know he feels comfortable with the AIDS activity that is ongoing. As far as I am concerned, Dr. Fauci can be spending his money now. That is our intent, to release that money on a regular basis to the institutes. They are not going to have to apply for pencils and supplies and I do not say that jokingly. I say that truly.

Mr. HOYER. I understand. I am concerned about that.

Dr. MACDONALD. That is what we intend to do, to release the $143 million to NIH.

Mr. HOYER. I do not think this Committee wants—and I will end with this, Mr. Chairman, I know I have gone overtime. We are going to slow up the effort if we bureaucratize it. I agree with the coordination. But if we slow the process down greatly with coordination and undermine the application of these dollars quickly that undermines congressional intent. Obviously that is the only reason Congress came up with so much money in such a quick fashion was to try to find as quickly as possible a diagnosis and some sort of vaccine if possible, and a cure if possible.

And we do not want that process slowed down.

AIDS BUDGET COORDINATION

Dr. MACDONALD. True, but I want to remind you where that budget came from. That budget came from the coordinating AIDS committee within the Public Health Service. It was not presented as an NIH budget or a CDC budget. It came up and was presented by the then Acting Assistant Secretary for Health. He said we need more money. We have agreed this is what we need, we being the agencies of the Public Health Service. It was collegially done and presented in a coordinated fashion even then. Maybe you were able to identify the chunks better then.

Mr. HOYER. All right, Doctor.

I am sure we are going to follow up closely, because we are all very concerned about it, as I know you are.

Thank you, Mr. Chairman.

Mr. NATCHER. Dr. Macdonald, for the record, if you will, please provide a table showing funding for AIDS activities by agency for Fiscal 1982 to 1987. And if you will, show two columns for 1986, one for the appropriated level and one showing the reduced level that you are proposing. And place that in the record for us, please.

[Information to be furnished follows:]

PUBLIC HEALTH SERVICE
ACQUIRED IMMUNE DEFICIENCY SYNDROME

(DOLLARS IN THOUSANDS)

					FY 1986					
AGENCY:	FY 1982 Actual	FY 1983 Actual	FY 1984 Actual	FY 1985 Actual	Approp.	Sequest.	Rescind	Estimate	FY 1987 Request	TOTALS
CDC..................	$2,050	$6,202	$13,750	$33,298	$64,925	$2,792	$11,848	$50,285	($45,409) c/	$150,994
NIH..................	3,755	21,668	44,121	63,737	140,723	6,051	13,915	120,757	(142,990) c/	396,628
ADAMHA...............	0	516	2,791	2,578	12,704	546	0	12,158	(13,733) c/	31,776
AIDS Coordination..	---	---	---	---	---	---	---	---	(1,350) c/d/	1,350
DASH.................	---	---	---	---	---	---	---	---	203,482 e/	(203,482) c/
HRSA.................	---	---	---	---	16,000 a/	688	15,312	0	---	---
Total Labor, HHS...	$5,405	$28,386	$60,662	$99,613	$234,352	$10,077	$41,075	$183,200 b/	$203,482	$580,748

a/ Appropriated to the office of the Secretary to fund four demostration projects on the delivery of health care services to victims of AIDS.
b/ Estimate for FY 1986 reflects effects of G-R-H reductions of $10,077 & rescissinn of $41,075.
c/ Non-adds. Reflects current allocation plans for distribution of AIDS resources.
d/ Provides $350 for PHS AIDS Coordinator and support staff, and $1,000 for expansion of the National AIDS Public Information Campaign.
e/ The Administration is proposing that funds(appropriated by the Labor, HHS committee) for AIDS research be requested
in a new account to be established in DASH.

*NOTE: Does not include funding for the Food and Drug Administration.

AIDS RESCISSIONS

Mr. **Natcher.** The budget is proposing 1986 rescissions for AIDS totalling $41,075,000.

Dr. Macdonald, why should we approve any further 1986 reductions for AIDS activities? How would we justify it?

Dr. **Macdonald.** The reductions are really rescissions of add-ons that were given to us at the Congress' will, at the end of the 1986 budget session. We are just asking that you reconsider some of those things.

One, that Mr. Young spoke of earlier, is the $10 million for the continuation of local efforts to provide alternative blood test sites. Our position is that those blood test sites are indeed marvelous and we are glad we did them. Our intent from the beginning, however, was that they would be, in time, a limited federal contribution to stimulate the government.

Two million dollars was included as an add-on for a national AIDS hotline, also a good idea. It is our feeling that, in terms of what you get for the dollar, we already have a CDC hotline that operates. It is screening something like 21,000 calls a month, a big operation. We saw this as money that we really did not need at this time.

There is money in the rescission proposal for an AIDS demonstration service delivery project, $15 million. In our opinion, that money also is not bad money and those projects are not bad projects. We think, however, much of what is covered in that demonstration has been covered elsewhere.

I might add that very shortly after that $15 million was put out, the Robert Wood Johnson Foundation decided that they also were interested and appropriated, from their foundation, $17 million to look at AIDS demonstration projects.

The $11 million for AIDS research is the one rescission proposal I know this Committee has been most interested in. It is our intention to ask for all of that back in the 1987 budget. In a rapidly growing field, and considering continuation costs, our feeling is that it is appropriate to put it off in this fashion.

Mr. **Natcher.** Dr. Macdonald, if Congress refuses to go along, now, with the rescissions, will you be able to use these funds in worthwhile activities, along the line indicated?

Dr. **Macdonald.** Yes, sir. As I have said with each of those things—the hotline for instance, we are always prepared to do the will of the Congress. The rescission is just a request on our part, for you to re-look and say do we really want to be spending money on that this year. If you decide that is what we are going to do, and it goes through the process, we will be there doing it.

AIDS PUBLIC INFORMATION CAMPAIGN

Mr. **Natcher.** How do you plan to utilize the $7 million that you are requesting for the National AIDS Public Information Campaign?

Dr. **Dowdle.** We are spending right now, primarily for CDC, something like—or, we will in '87—something like $25 million on information education programs aimed primarily at risk reduction among high risk groups. And what we need, and are planning to do with this $1 million, is to provide information on AIDS to the general public, to the public at large.

This is an area in which we feel that we need to increase our efforts. There will be a number of different information programs. A national coalition has been set up to coordinate programs, working with AMA and with other professional organizations, the Red Cross and so on and so forth. We will also try to direct some of our information and education programs to high schools, to youth, and to general groups.

So we feel that the $1 million would support a much needed program, which can be very effective in the long term.

Mr. **Natcher**. Thank you, Dr. Dowdle.

ADOLESCENT FAMILY LIFE PROGRAM

You are requesting $14,722,000 for the Adolescent Family Life program, which is not authorized for 1987. Do you have any results or findings yet from the demonstration projects that have been funded?

Dr. **Macdonald**. The Family Life Program, as you know, is a new program and the demonstrations that were begun in 1982 are mostly five year demonstrations. So we do not have any final results yet.

I might ask Ms. Gasper to comment on a couple of things. One thing that we have noticed is that in those areas where care is provided for the adolescent in pregnancy, outcomes are improved and there is evidence that the rate of second pregnancy has also decreased.

Ms. **Gasper**. We will soon have completed a compendium of each of our projects that have been funded, stating what the intervention is and what the findings to date have been.

As Dr. Macdonald pointed out, many of our initial projects are just now coming to completion because they were funded for five years. This compendium includes both the most up to date information on these early projects and also information on the projects which have been started more recently.

We should have the compendium out very shortly. We find, as was pointed out earlier, that the health status of the infants born to clients of our grantees is better than that of the general population. We also have a higher placement for adoption than national averages.

We are seeing a great deal of support from the families, the parents, the young mothers, and the communities where we have demonstrations.

Mr. **Natcher**. Ms. Gasper, what efforts do you make to disseminate these findings around the country?

Ms. **Gasper**. We have established a Data Archive that has information regarding adolescent pregnancy. We are going to be disseminating or letting people know about the compendium when it is finalized. We have had discussions inside the office regarding improving our dissemination activities. We are building mailing lists of organizations and parties who are interested in information that we have, so that we can keep them informed as more data becomes available.

DEMONSTRATION PROJECTS

Mr. **Natcher**. Why is it necessary to fund 36 new demonstration projects in 1987?

Ms. **Gasper**. These projects will replace earlier projects that have completed their funding cycles. This program was designed to support demonstrations that will be picked up and supported by local efforts after three to five years of Federal support. Each year, we will be funding new projects to continue our level of effort.

Mr. **Natcher**. Does the Administration see this as a temporary program or does it plan to continue funding new projects indefinitely on into the future?

Ms. **Gasper**. We have requested reauthorization for three years.

ADOLESCENT FAMILY LIFE STAFFING

Mr. **Natcher**. You are requesting $1,299,000 and 17 full-time employees for program support for the Adolescent Family Life Program, an average cost of $76,412 for a full-time employee. Why is the cost per full-time employee so high, Ms. Gasper?

Ms. **Gasper**. I will have to check our personnel records and operating budgets.

Mr. **Natcher**. For the record, if you will, provide a list of positions in this program, showing the duties and the salaries for each.

[Information to be furnished follows:]

AFL Program Support Costs

The FY 1987 budget request of $1,299,000 for Program Support includes funds for contractual activities as well as personnel and related costs. In addition to the personnel costs, examples of these other managerial, administrative and overhead requirements include: contracts for reviewers of demonstration grant proposals; the Interagency Agreement with the National Institutes of Health to conduct peer review of research proposals; SLUC; personnel benefits; charges for agency provided services, i.e. fiscal, personnel, computer, etc.; travel; assessments; and miscellaneous items like office machine maintenance contracts, printing, supplies and equipment.

The 17 FTEs allocated to the Adolescent Family Life program are shown on the listing below by position and incumbent's salary. The average salary cost of the 17 positions shown below is $37,326.

Position	*Salary*
Director—GM 15	$52,262
Deputy Director—GM 15	60,761
Grants Management Officer—GM	55,369
Program Analysis Officer—GS 14	50,484
Statistician—GS 13	38,852
Technical Information Specialist—GS 13	48,876
Program Development Specialist—GS 13	42,611
Program Analyst—GS 13	32,673
Program Analyst—GS 12	31,619
Program Analyst—GS 11 (Vacancy)	26,381
Grants Management Specialist—GS 12	34,781
Administrative Officer—GS 11	31,655
Grants Management Assistant—GS 7	19,012
Grants Technical Assistant—GS 7	22,576
Secretary—GS 7	23,170
Secretary—GS 7	19,606
Program Evaluator—Expert	43,848
Total salary costs	$634,635

NCHSR BUDGET INCREASE

Mr. **Natcher**. Turning to the National Center for Health Services Research, why is an increase of $3.3 million needed for the National Medical Expenditure Survey? And also tell us how this survey is actually done.

Dr. **Macdonald**. I will ask Dr. Marshall to give you the specifics, but the reason for the increase is that this is the survey that is going to the field and the additional money reflects the data-gathering costs. It is going to be a very extensive survey, looking at changing medical service and delivery in a changing system, looking at the changes in a time of DRGs and prospective pay systems, changing Medicare requirements in states, and changing insurance bills.

We will look at approximately 13,500 households and a 10,000 institutionalized population and, on a very regular basis, weekly, visit them and talk to them about their medical experience to get information that will be very valuable as a basis on which to make health care decisions of the future.

John, do you want to add anything?

NATIONAL MEDICAL EXPENDITURE SURVEY

Mr. **Marshall**. Yes. I must correct you. It is quarterly that we will call back to them. But they will be given a log that they will fill out, between visits from the people who are conducting the survey.

It is a very massive undertaking and the major expenditures come from the kind of contractor personnel staffing that you need to go to almost 14,000 households and return to each of those households every three months as well as to go to the places where long-term care is provided.

This will be as complete a survey as we can, that will indicate what the effects are of HMOs, which we now have about 20 million Americans enrolled in, and changes that are occurring in insurance coverage that people have, none of which we understand very well at the present time.

We will also be oversampling, for Blacks and Hispanics in order to get a better understanding of the needs of those populations and we have arranged with the Indian Health Service to put money into this activity for us to answer similar kinds of questions for the Indian population.

Mr. **Natcher**. Dr. Marshall, what is the difference between this survey and the National Medical Care Utilization and Expenditure Survey conducted by the National Center for Health Statistics?

Mr. **Marshall**. This is a follow-on to that. The last sample for that particular survey was drawn in 1980. In the intervening period of time, there have been major changes in the health care financing industry and changes in how health care is delivered. And so, we believe that by seven years later, it really is time for us to start understanding more about that.

We have carefully coordinated this with not only the National Medical Care Utilization Expenditure Survey of 1980, but an earlier survey which our organization did in 1977 which got this kind of data. So we will, in addition to having a picture of what the status is in 1987 and early 1988, be able to compare that with where we were at in 1980 and 1977.

Mr. NATCHER. Thank you, Dr. Marshall.

Mr. Conte, I yield to you.

Mr. CONTE. Thank you, very much.

TEENAGE PREGNANCY

There has been a great deal of attention lately focused on a tremendous problem of teenage pregnancy. What percentage of births in this country are to teenagers?

Dr. MACDONALD. In the black community it is 25 percent and in the white community I think that number is 12 percent or 12 and a half.

Mr. CONTE. And what percentage of those teenage births are to parents out of wedlock?

Dr. MACDONALD. We estimate 500,000 teenage births a year, half of which are out of wedlock. When you drop to that unfortunate population under the age of 15, which is 10,000 births a year, 90 percent are out of wedlock.

Mr. CONTE. What more should we be doing to try to deal with this problem, assuming, I guess, that you would agree that it is a problem.

Dr. MACDONALD. There is absolutely no question that this is a problem, and the concerns about infant mortality and infant morbidity are serious. The outcome in terms of what happens to the mother who has a pregnancy are most often negative. Her education is frequently interrupted or halted, at least her formal education, and she frequently ends up on the welfare rolls. We have a very distressing problem, with lots of economic and social costs and consequences.

Those areas that Dr. Nickens will look at are related to specific problems of minority populations. But it is more pervasive than that and deals with issues of family, issues of child rearing, issues of education, issues of support for kids.

As I mentioned earlier, we need more research on understanding just exactly what is going on. It is a huge problem, and many programs of the Public Health Service are involved in looking for answers. As you know from the President's speech, he also is greatly concerned about this issue, and when Dr. Bowen listed his priorities and what was important to him at the time of his confirmation, family issues was very high on that list.

Mr. CONTE. I will be interested in seeing what more we can do in this area because something more has to be done than what we are doing now. We think we know what the reasons are, but how do you correct it? How do you change what is going on? It is a real challenge.

EFFECT OF GRAMM-RUDMAN-HOLLINGS ON TITLE X

Regarding Gramm-Rudman-Hollings, we see some indication that some of the nondirect service components such as technical assistance were held harmless while direct service allocation, Title X clinics, was allowed to bear the full brunt of the sequester. Please describe in detail how the Gramm-Rudman-Hollings sequester was taken and indicate why, in light of the previous discussions on teenage pregnancy, it didn't do the opposite, which is to reduce nondirect services as much as possible in order to preserve direct service funding.

Ms. Gasper. If I may address that, Mr. Conte, in Title X we took an across-the-board cut of 4.3 percent as the Gramm-Rudman-Hollings reduction. Under the program, there are various categories of things that we do, direct services, training, information and education, and service delivery improvement. In each of those major categories, we took the same 4.3 percent cut.

Under the service delivery improvement component of Title X, there is a contract which provides technical assistance to our grantees, and we held that harmless. We held it harmless because to have cut it would have required renegotiation of a signed contract. It would only have freed up an additional $28,000. We felt that we could take that $28,000 out of other components of the service delivery improvement activity.

We have provided the full amount of services funds to the regions, that we provided initially in FY 1985 less an across-the-board 4.3 percent cut. I should add that we felt that, given the budget constraints that our grantees are going to be operating under, they would need the technical assistance to help them more under the budget constraints.

Mr. Conte. In the fiscal year 1987 bill, assuming no Primary Care block grant and few, if any, increases, why shouldn't we eliminate or cut back funding for nondirect services, like service delivery improvement projects, which have been unproductive lately, as far as I can see, in order to get the maximum amount for direct services?

Ms. Gasper. We feel that the service delivery improvement component is an integral part of Title X and it is necessary so that we can provide our grantees with up-to-date information on how they can better deliver services, and it is particularly important during constrained budget times.

TITLE X DATA COLLECTION

Mr. Conte. What progress have you made in implementing the mandated information-gathering service which was destroyed by your predecessor? Take us through step by step what you have done.

Ms. Gasper. Last year there was concern raised regarding our data collection activities. Mr. Waxman introduced legislation and amendments to the Title X reauthorization that would require certain data collection activities. I am glad to report that we have looked at the data issues. We are concerned about them the same way you are. We feel that we do need quality, reasonable data to fulfill our management responsibilities and to be able to provide you with the information that you reasonably ought to have.

After a serious examination of a range of options, we have decided to propose some minor changes in the Bureau of Common Reporting Requirements (BCRR) to get the data that we need. We have looked at a whole range of options, and I did not want to take money out of services—I mean we could do a lot of data collection, but it could also be very expensive. I felt it was important to maintain our priorities on providing services, and to use the resources that we had available to upgrade what we are doing with the BCRR. We are in negotiations now with HRSA to get the new data elements in the BCRR, and I am looking forward to having them in place as soon as possible.

Mr. CONTE. For the record, please update your answers to the question you answered last year, starting on page 137 of the hearing record under the heading "Family Planning Data." Also update your answer on natural family planning and indicate whether you feel we are doing enough in this particular area.

[Information to be furnished follows:]

DATA COLLECTION

A considerable amount of effort has been expended in the search for a system of data collection more in pace with the Family Planning program's requirements. We have examined several options and have proposed the following changes based both on program needs, feasibility of implementations and budgetary constraints.

The development, testing, and implementation of a completely new data collection system at the more than 4,000 Family Planning clinic sites was not considered feasible at this time because of the current budget constraints. It is our position that maximum emphasis should be placed on provisions of services. As a result, consideration of data options was limited to options which could be implemented at minimal cost—and therefore minimal diversion of funds from services to data collection. The Office of Population Affairs (OPA) has proposed instead a plan to modify the current Bureau Common Reporting Requirements (BCRR) system to better support the data collection requirements of the Family Planning program. The proposal was sent to the Acting Director of the Bureau of Health Care Delivery and Assistance (BHCDA), which operates the BCRR system for all programs. It is expected that comments and discussions concerning implementation will begin shortly. The proposed plan expands collection of patient characteristics in the following areas:

Age—The current BCRR reports age in two categories: less than 20 years and over. There are important differences in family planning services utilization patterns between older and younger adolescents and adults. By expanding the age variable into four categories, under 15, 15–19, 20–34, and 35 and older, some of these differences can be captured.

Sex—The current BCRR reports on female patients only. Even though males represent only a small proportion of patients, Title X services are extended to males and there should be a mechanism for reporting such services.

Race—BCRR does not currently report race. As with age, there are differences in utilization patterns between races. Including patient counts by race would facilitate documenting this for Title X programs, as well as tracking any changes over time.

Poverty status—The current BCRR reports poverty status in two categories above and below 150% of poverty. Expanding this variable into four categories (less than 100% of poverty, 100–150% of poverty, 151–250% of poverty, and greater than 250% of poverty) would provide a more precise distribution of the patient population into poverty, low-income, and above low-income groups.

Contraceptive method—The current BCRR does not report contraceptive method. Considering advances in contraceptive technology—new methods of contraception, as well as research findings on both beneficial and harmful side effects of existing contraceptives—data on contraceptive method use are important for effective administration of Title X programs.

Type of service—The current BCRR does not report type of service. The proposed service variable is designed to provide some measure of service intensity, as well as the type of service received. Family planning visits are classified as: contraception (medical); sterilization; and infertility—associated with the receipt of medical services—and contraception (other); and counseling—not associated with the receipt of medical services.

NATURAL FAMILY PLANNING

Service providers receiving Title X funds are required by legislation to provide Natural Family Planning (NFP) services onsite or through referral and report on these services annually. The program staff is both encouraging and supporting this requirement by providing training and technical assistance and supporting pertinent research. A partial listing of these activities includes:

General staff training and technical assistance in NFP is provided to all grantees through training grants and a technical assistance contract. NFP areas in which service grantees have received training and technical assistance are: identifying target populations and outreach, developing a NFP community education campaign, and developing materials for teaching NFP.

A Service Delivery Improvement grant was awarded for a research study investigating the benefits of group versus individual instruction of NFP. (NFP was added to the list of research topics included in the standing announcement requesting RFPs for research grant awards.)

A number of NFP projects have been supported by National Priority Project funds in the Regional Offices. One project which has been completed involved the production of a state-wide directory of providers of NFP services in California.

A contract with the Los Angeles Regional Family Planning Council (LARFPC) for the development and enhancement of NFP services at sites in each of the 10 DHHS regions has just been completed. Some 46 different agencies benefited from the technical assistance and over 33 new NFP instructors were certified—15 additional instructors are awaiting certification.

The LARFPC contract also provided for the development of a client education pamphlet and curricula for nursing and medical students. These materials are currently being reviewed prior to publication.

Ms. GASPER. We will be glad to do that.

NCHSR AND NCHS BUDGET INCREASE

Mr. CONTE. In your budget, Dr. Macdonald, you not only restore Gramm-Rudman-Hollings cuts for activities in health services research and health statistics, but you request substantial increases of $5.6 million in fiscal year 1987 for those activities. Out of all the activities that are cut by Gramm-Rudman-Hollings and not restored, why should these activities have such a priority that they are not only restored but increased?

Dr. **Macdonald**. In the PHS Management appropriation, we have restored our sequestered money in 1987. The two increases you mentioned address two major surveys—the one that Dr. Marshall spent time explaining, the National Medical Expenditure Survey, and the other is the National Health and Nutrition Examination Survey, which is looking at the nutritional status of the country. That is a periodic survey, and it is scheduled to take place in 1988, and 1987 money is included to continue preparation for data collection.

NCHSR OFF-BUDGET RESOURCES

Mr. **Conte**. I don't understand your budget for the National Center for Health Services Research and Health Care Technology Assessment. That must be the longest title in the United States Government. You are going to have to explain to me the transfer reflected in that budget of $5.1 million for funds authorized under Section 5(h) of Public Law 98-551, and $1.2 million for national research service and awards authorized under Public Law 99-158.

What are these two transfers, and what do they do and where does that money come from?

Dr. **Macdonald**. One of those transfers is from the one percent evaluation funds. Congress stipulated that 7.5 percent should go to that long-named NCHSRHCTA. The other transfer comes from the National Research Service Awards. Of the funds appropriated for the National Research Service Awards, one-half of one percent goes to NCHSR under Public Law 99-158.

Mr. **Conte**. Is that NIH?

Dr. **Macdonald**. This comes from the research money which would be NIH and ADAMHA, mostly NIH.

Mr. **Conte**. Don't these funds already provide the NCHSR with a substantial increase in funding over previous years' base funding?

Mr. **Forbush**. The evaluation funds, in particular, do give them a substantial increase. But the research service awards are still research training awards, but research training in health services research. It is not like the funds are being diverted into other than training for researchers.

USER LIAISON PROGRAM REDUCTION

Mr. **Conte**. Still on the NCHSR, you created quite an uproar when you decided to take your Gramm-Rudman-Hollings cut by eliminating the user liaison program, and I heard from the Commissioner of Public Health from Massachusetts on this, I heard from the state legislators in my own district. Tell me about this program and why you decided to eliminate funding for it. What good is research if you don't have outreach?

Dr. **Macdonald**. I would agree with the last comment that outreach is important. In the law it is stipulated that NCHSR needs to spend at least $1.5 million a year, or 10 percent of their research money, for three activities, of which one is the user liaison function. All of these are directed at transfer of knowledge, so collectively they are called the user liaison program.

There is also a stipulation that technical assistance to states and others be included as well as general dissemination activities. In

1987, we will continue to disseminate information by using other methods.

Dr. Marshall, in advising us on how he wanted to make his budget cut, pointed out that a significant percentage of the money that goes into the user liaison program is overhead costs, costs of contractor charges, cost of transportation, and cost of housing. We are hoping that people will understand that we don't think it is an unimportant activity but that there are in 28 states, 35 centers which are capable of delivering that information.

The information that is disseminated is generally not information that we have generated ourselves. So at a time of having to make a budget cut, Dr. Marshall—and I agreed with him—said that this looks like a program that we can supplant by other methods rather than taking the money from other high priority activities.

Mr. **Conte**. For the record, will you put something in here as to why the user liaison program isn't considered a program, project, or activity, given its mention in the Senate report, and so limited to only the 4.3 percent cut?

[Information to be furnished follows:]

User Liaison Program

The User Liaison Program of the National Center for Health Services Research is not considered a program, project or activity under The Balanced Budget and Emergency Deficit Control Act of 1985.

This Act requires that, for programs subject to the across-the-board reduction, the required 1986 reduction of 4.3 percent must be applied to all "programs, projects, and activities" as defined pursuant to Sec. 101(h) of P.L. 99-190. This definition includes "budget items identified in . . . the House and Senate Committee reports (H. Rept. 99-289 and S. Rept. 99-151) . . . " accompanying the appropriation for the Departments of Labor, Health and Human Services, and Education and Related Agencies; and " . . . the tables inserted on pages H10915 through H10940 of the Congressional Record of December 5, 1985." In applying this definition, the Department identified all programs, projects, and activities mentioned in the House and Senate reports for which there was a clear reference to a specific funding level.

The research operations of the National Center are subject to the 4.3 percent reduction as a single activity because it is identified as a separate program in the table published in the Congressional Record of December 5. However, the User Liaison Program, which is an element of the National Center's research efforts, was not designated as a separate activity under the Balanced Budget Act. The House Report did not mention this activity and the Senate Report only indicated the expectation that support continue "at appropriate levels." Since no budget amount was indicated for the activity, the conclusion was made that it could not be designated as a budget item entitled to be accorded "program, project, or activity" status under the Act.

Mr. **Natcher**. Mr. Stokes.

AIDS EDUCATION AND RISK REDUCTION

Mr. **Stokes**. Thank you, Mr. Chairman.

Dr. Macdonald, you may have given us this figure earlier. How much are you spending on AIDS education and risk reduction strategies?

Mr. **Macdonald**. We are asking for approximately $25 million at CDC.

Mr. **Stokes**. My understanding is that that one out of every four AIDS victims is black. Is that figure correct?

Mr. **Macdonald**. Yes, sir.

Mr. STOKES. Do you have any programs that are particularly targeted toward this group?

Mr. MACDONALD. I will ask Dr. Nickens to help me answer that. Unfortunately, many of the black patients with AIDS fall into the drug-using population. It is a very difficult population for us to get a handle on. They are disproportionately represented in that group. We are involved with promotional or prevention activities and educational activities there.

Dr. NICKENS. I have begun some conversations with the ADAMHA AIDS coordinator because a lot of this does fall into psychosocial support and initiatives. I have also begun some conversations with the National Medical Association specifically about getting involved in this area, and they are very interested. So those are the things that we have started to do already. I don't know if there is more.

Dr. DOWDLE. Well, there is another group, of course, that has been very difficult to reach, and that is members of the black gay community. We have also had discussions with some of the states and some of the local groups to try to design education programs to be effective for those populations. So there are a number of ways in which we are looking at this.

Part of the $1 million we mentioned earlier for general information and education on AIDS, will be directed towards specific populations groups.

Mr. STOKES. But, if I understand you correctly, you are aware of the problem, you are contacting various groups, but at the current time, you are not really targeting your efforts toward this particular group.

Dr. DOWDLE. Part of the difficulty up until now, and I think as part of the discussions that Dr. Nickens and I have had, is that it is very difficult to know exactly how to frame the message and how to get the message in the right channels to some reach of the groups. That is one of the problems.

Mr. STOKES. I see.

CIGARETTE SAFETY ACT

Dr. Macdonald, on another subject, cigarette ignitions of upholstered furniture and mattresses are a leading cause of fire deaths in the United States. In 1984, Congress passed the Cigarette Safety Act, which directs a thorough study of the feasibility of manufacturing safer cigarettes. To carry out this study, I understand that the Consumer Product Safety Commission, FEMA and Department of Health and Human Services established a committee which is working on a final report to Congress due in October 1987.

I understand further that the Consumer Product Safety Commission and FEMA have contributed significant amounts towards the study. Can you tell us how much the Department of Health and Human Services has contributed?

Mr. MACDONALD. If I may, I would do that for the record, Mr. Stokes.

Mr. STOKES. Yes.

[Information to be furnished follows:]

CIGARETTE SAFETY ACT

The "Cigarette Safety Act of 1984," P.L. 98-567 was enacted October 30, 1984. The law requires the establishment of an Interagency Committee on Cigarette and Little Cigar Fire Safety (IC) to be chaired by the Chairman of the Consumer Product Safety Commission. In addition to the Chairman, the Interagency Committee includes the U.S. Fire Administrator, Federal Emergency Management Agency, who serves as Vice Chairman, and the Assistant Secretary for Health, Department of Health and Human Services.

"The Cigarette Safety Act" also established a Technical Study Group on Cigarette and Little Cigar Fire Safety (TSG) whose work is to be directed, overseen and reviewed by the Interagency Committee. The TSG, under the oversight of the IC, is to determine the technical and commercial feasibility, economic impact, and other consequences of developing cigarettes and little cigars that will have a minimum propensity to ignite upholstered furniture or mattresses.

Subsequent to enactment of P.L. 98-567, the Consumer Product Safety Commission received $500,000 in FY 1985 supplemental funding from Congress to assist in carrying out the provisions of the Act. The FY 1986 appropriation for the Consumer Product Safety Commission contained $1,000,000 for this purpose. In addition to these appropriated funds, the Consumer Product Safety Commission and the Federal Emergency Management Agency each have provided $150,000 from their operating funds in support of the Technical Study Group's activities. The Department of Health and Human Services, through direct operating funds from the Office on Smoking and Health, has provided $8,000 towards TSG travel expenditures.

On February 15, 1985, the Technical Study Group issued a Working Paper on Resource Needs Assessment. This paper outlined study areas that included: an ignitability measurement project; testing of cigarettes in 100 variations of size, shape, length, etc. to verify sample specifications and uniformity; a study of fire losses and burning characteristics; and, an evaluation of the commercial manufacturing feasibility and consumer acceptability of cigarettes and little cigars with reduced undesirable ignition propensity.

Based upon Departmental review of the study areas, it was determined the Public Health Service support of these activities would not be consistent and appropriate under our legislative authority. Therefore, Departmental support of the TSG activities has been limited to the funds previously provided by the Office on Smoking and Health.

Mr. STOKES. I am given to understand that about $605,000 is needed to complete the study and that, thus far, the Department has declined to provide any additional resources. If you would also respond to this matter, I would appreciate it.

ADOLESCENT FAMILY LIFE ACCOMPLISHMENTS

Are there any accomplishments that you can cite for the Adolescent Family Life Program?

Dr. MACDONALD. The initial Adolescent Family Life Program demonstrations were awarded in 1982 and are due to be completed sometime in 1987. We have some preliminary information that is of value, which shows that if you do provide care to adolescents who are pregnant, that indeed you can improve outcomes for them, and you can also decrease the chances of them going on and becoming pregnant a second time.

We also have preliminary indicators, that if you can strengthen the family communication, that is, the parent/child interaction, you can positively affect outcomes.

TEENAGE PREGNANCY

Mr. STOKES. In response to Mr. Conte's question regarding teenage pregnancies, you gave us some statistics regarding black teenage pregnancies.

Dr. MACDONALD. Of black pregnancies, 25 percent are teenagers.

Mr. STOKES. I see. About 12 percent of white pregnancies are teenagers?

Dr. MACDONALD. Yes, sir.

Mr. STOKES. Now, under the age of 15, what are your findings?

Dr. MACDONALD. I don't have that information on adolescent pregnancy by race. Data on teenage births show that under age 15, there were 4,153 white births and 5,395 black births in 1983.

Mr. STOKES. So, there are more pregnancies among black teenagers than white teenagers under age 15.

Now, do we have any data on whether in both races these teenage pregnancies resulting in children are on an increase or a decrease?

Dr. MACDONALD. The pregnancies?

Mr. STOKES. Yes. Well, both the pregnancies and the births.

Dr. MACDONALD. Well, the births are generally down, and the pregnancies are generally up, but neither one of those in major form. By race, data on pregnancy is not available. We do have data for births and sexual activity. Birth rates, for both races, have declined since 1970. They have been relatively stable for the past few years for white teens and continue to decline for black teens. Before 1976, sexual activity rates were rising in both races. Between 1976 and 1979, the black rate leveled off. and the white rate continued to climb. From 1979 to 1982, there is a slight decline in the black rate, and now the white rate is starting to level out. So in that one regard, the black pregnancy picture is better than the white.

Mr. STOKES. Okay. What do we know about abortions in both groups?

Dr. MACDONALD. The abortion numbers I have are not broken down racially.

Mr. STOKES. I see. Is the issue of teenage pregnancy something that you have studied with reference to how we address what is obviously a national problem?

Dr. MACDONALD. Yes, sir. It's a problem with many facets. It has parts that are related to parenting, part of it is related to what are the causes of infant mortality in a teenager that make them more at risk. It has parts that are related to a better understanding of why infants die in that period of time.

The Adolescent Family Life Program asks a lot of those important questions, and some of those early responses that we're seeing, if they prove to be something that can be replicated, will be helpful.

In other words, prenatal care may help prevent recurring pregnancy. Strengthening families may prevent a high rate of pregnancy among teens. There are lots and lots of issues, and we are very interested in spending time and effort to examine them. Mrs. Gasper in the Office of Population Affairs, and Dr. Nickens in the Office of Minority Health—both see this as major responsibilities of their offices.

Mr. STOKES. From what I understand, there is a commitment to really study this issue in-depth and spend some resources. You are looking at this entire problem and all of its facets, is that correct?

Dr. MACDONALD. Yes, sir.

Mr. STOKES. Thank you very much.

Thank you, Mr. Chairman.

Mr. NATCHER. Mr. Early?

Mr. EARLY. Thank you, Mr. Chairman.

NEW AND ONGOING AIDS ACTIVITIES

Dr. Macdonald, what portion of the $203,482,000 in AIDS is for ongoing activities, existing commitments, and what portion for new commitments?

Mr. LITTLE. I don't have the total dollar estimates. I have the estimates for the number of new and competing grants and for the continuation grants.

Mr. EARLY. Why don't you provide it for the record in detail, and provide the breakdown by agency.

[Information to be furnished follows:]

PUBLIC HEALTH SERVICE ACQUIRED IMMUNE DEFICIENCY SYNDROME [AIDS]

[In thousands of dollars]

	Ongoing activities/existing commitment	New commitments	Fiscal year 1987 total request
CDC	45,409		45,409
NIH	131,842	11,148	142,990
ADAMHA	11,948	1,785	13,733
OASH	250	1,100	1,350
Total	189,449	14,033	203,482

AIDS APPORTIONMENT PROCESS

Mr. EARLY. To follow up on Mr. Hoyer's questions, will all of this have to go through the regular apportionment process before funds can be released to the individual agencies?

Dr. MACDONALD. I didn't hear that question.

Mr. EARLY. Will OASH have to go through the regular apportionment process before it can release funds to individual agencies?

Dr. MACDONALD. Yes, sir.

Mr. EARLY. Yes?

Mr. FORBUSH. All appropriations are apportioned. It is required by law. I would distinguish that, however, from a spending plan that we would work out in advance. The apportionment will apportion the funds by quarter. The receiving agency will know in advance what their total funding is. The funds will be available as apportioned by quarter for their use.

Mr. EARLY. Well, Dr. DeVita at NCI is going to have to go back to Dr. Dowdle, who is going to give him back the money—

Dr. MACDONALD. No, that would not change, would it?

Mr. FORBUSH. No, I don't think that that would be required. One can make funding allocations and commitments so that as far as the accounting records go, those funds are in their accounts when they need to obligate them.

Mr. EARLY. Are we positive that is OMB's intention as far as——

Mr. FORBUSH. It is certainly our intention in administering it.

Mr. Early. We know, Dr. Macdonald. I listened to you, and you say you could transfer $86.8 million without the committee's permission. But that's not our intention, you said.

Doctor, did you ever have intentions for multiyear funding a couple of years back? Did you think anyone on this committee wanted multiyear funding before Mr. Stockman multiyear funded everything?

Dr. Macdonald. Yes, sir. It was clear how the committee felt.

Mr. Early. What about yourself?

Dr. Macdonald. I was taken by surprise.

Mr. Early. So our intentions sometimes don't really happen. So if you would just expand on that for the record, as far as each agency is concerned, and also specifically put in, Mr. Forbush, OMB's intention is not to run through that process again.

INTRAMURAL AND EXTRAMURAL ACTIVITIES

Doctor, I understand that funds for both extramural and intramural activities are included in this request, correct?

Dr. Macdonald. Correct.

Mr. Early. In the case of intramural activities, does that include both the salaries of the intramural personnel and a portion of the agency's FTE allocations?

Dr. Macdonald. Yes, sir. The funding in this appropriation includes all research funds, including salaries for intramural researchers.

Mr. Early. Well, that adds a little more paperwork.

Mr. Forbush. The FTEs are in the agency total. We have not budgeted centrally for the FTEs. We have only associated five FTEs with this account for the Assistant Secretary's office.

AIDS COORDINATION

Mr. Early. Doctor, what kind of decision-making authority would Dr. Dowdle have as the AIDS Coordinator? The justification isn't too specific in what area.

Dr. Macdonald. The way it works now, Dr. Dowdle makes all of the decisions. We talk together a half hour every day. We have had no problems with this process. Dr. Dowdle is a representative of the Assistant Secretary, who makes the decisions.

Mr. Early. I think he's going to do a fine job. But, you know, when OMB, when you're with just OMB, I have a lot of reservations, a lot of reservations.

What kind of an appeal process would there be for the agencies, CDC, NIH? Will there be a process by which an agency can appeal a decision of the Coordinator?

Dr. Macdonald. Absolutely. Dr. Dowdle is not making any decisions on issues that he hasn't discussed and reached agreement on with the agencies involved and with the Assistant Secretary.

There is an ongoing process of two meetings held every other week, which include the AIDS Coordinating Committee—all the agencies attend—and the Agency Heads' meeting that Dr. Dowdle attends. Hopefully the process would be collegial all the time.

Mr. Early. I just have a problem—the existing commitment, Doctor, it was never our intention—it was never my intention, when we started speaking of a Coordinator, to go to NCI and say, "What are you spending for this clinical trial?"

Doctor, let's say we were extremely fortunate and discovered a cure for AIDS ten months from now. Would the amount of money that has been taken from the individual agencies for this account go back to the individual agencies? None, would it?

Dr. **Macdonald.** I guess that's a problem with which I would like to have to deal.

[Laughter.]

Mr. **Early.** Oh, I would, too. But specifically, for example, what would happen to the intramural labs and personnel that were doing other research prior to shifting to AIDS?

Let's take Dr. Gallo's lab, for example. They were working on retroviruses before shifting to AIDS. Would NCI get its money back, or would it have to absorb it within its own appropriation, the cost of continuing that lab?

Dr. **Macdonald.** The 18,000 grants policy that we are looking at in the Institute says that there is flexibility in shifting. When AIDS came up on line quickly, we reassigned people or people changed careers. Money was shifted to meet the scientific need and opportunity, and I think the same would happen in this situation.

Mr. **Early.** But we want flexibility for the professionals, for you, for Dr. Dowdle, for Dr. DeVita. I mean, I wanted that before I had multiyear funding. OMB ended up taking away all the flexibility on that, and if it happened once, they can suggest it again.

And to one of Mr. Conte's questions you said there would be more flexibility for Dr. Dowdle. But for the existing monies, the more flexibility he has on the existing monies, the less Dr. DeVita has in his Institute, doesn't he, Doctor?

Dr. **Macdonald.** Yes, I understand your concern. That question of flexibility is always one that has to bother the Congress. The science manager would always like to get a lump of money on the basis of what he saw as emerging scientific opportunity and would make adjustments. Dr. DeVita would do that; Dr. Wyngaarden would do that.

All we're saying is that AIDS affects all of the Public Health Service agencies, and we're talking about the same process.

Mr. **Early.** Well, I can see what the intention for the coordination was, really, but not to get at the existing funds. That's what I was really surprised with.

Now you're talking—let me ask you, Dr. Dowdle, in my last three minutes here—five additional people—I see independence, coordination, if you haven't got another bureaucracy. Then those five people have to justify their existence.

PHS AIDS COORDINATOR STAFFING

What do you need $350,000 for, for that?

Dr. **Dowdle.** Of the $1,350,000 that is being requested, $1 million is for a general information program. The five positions, won't necessarily be working directly under the Coordinator. There will also be other AIDS-supported areas, in other words, some of the existing operation now going on in the Public Health Service.

Mr. **Early.** But if it isn't under you, where are they?

Dr. **Dowdle**. They are part of the support of the operation within the organization, but they wouldn't necessarily work directly with me.

Mr. **Early**. Well, I read that justification, and I thought you needed the 5 FTEs to support the AIDS Coordinator.

Dr. **Dowdle**. That's correct. But it's a question of whether they would be directly in my office. It's a matter of semantics.

Mr. **Early**. OMB makes semantics very difficult. What kind of positions are the five you requested?

Dr. **Dowdle**. The initial thought regarding these positions was that there would be the Coordinator, an Assistant Coordinator, an analyst, a secretary and a clerk. That was the initial suggestion.

Mr. **Early**. Can't you redirect those positions from other areas of OASH now?

Dr. **Dowdle**. Do you mean do those positions exist?

Mr. **Early**. Right.

Dr. **Dowdle**. They do not exist at present for that particular job.

Mr. **Early**. Are you or are you not requesting new positions for the AIDS Director?

Dr. **Dowdle**. We are requesting five new positions for AIDS.

Mr. **Early**. At $350,000?

Dr. **Dowdle**. Yes, sir.

Mr. **Early**. How much is that for salaries?

Mr. **Little**. Two hundred forty one thousand dollars are for salary and benefits.

Mr. **Early**. We are talking at least in the area of five at $50,000? There are no secretaries in there?

Dr. **Dowdle**. Yes, there would be a secretary.

Mr. **Early**. What is the salary of the Coordinator?

Dr. **Dowdle**. The Coordinator's salary is about $70,000.

Mr. **Early**. I am not asking the question because I think it is too much. Dr. Macdonald, specifically, on the question of money going back to the National Cancer Institute, the example I used, what was your specific answer to that?

AIDS CURE

Dr. **Macdonald**. What would happen if we cured AIDS tomorrow?

Mr. **Early**. Yes, in Dr. Gallo's lab. We had a major problem with the retroviruses that he was working on. Would OMB again be able to——

Dr. **Macdonald**. I do not know the answer to that question and I would supply it for the record. We are still with our 18,000 grants and with our intramural research program.

Mr. **Early**. Do you think we have the 18,000 like we used to? Now we get the same number but we keep going down on the monies. We have had several Directors saying they would rather fund fewer grants and give them enough money to really do it.

Mr. **Forbush**. Dr. Gallo's laboratory is inside the National Cancer Institute (NCI). If there were less work in AIDS going on there and they wanted to maintain the same sized staff, they would have to get some funding from the non-AIDS part of the NCI appropriation.

Mr. **Early**. That is my problem as far as if that was to happen. Then the monies would revert back and OMB could do what it wanted and you would have to come in for more financing.

Thank you.

Mr. **Natcher**. Mr. Hoyer.

ALLOCATION OF AIDS FUNDS TO AGENCIES

Mr. **Hoyer**. Dr. Dowdle, let me follow up on Mr. Early's questions. As I understand it, in the figures that Dr. Macdonald gave. $143 million at NIH, $46 million at CDC and $13 million at ADAMHA, is it your expectation that those three agencies can in effect plan on those sums of money?

Dr. **Dowdle**. Yes, sir.

Mr. **Hoyer**. Those are allocated in terms of your planning process?

Dr. **Dowdle**. Yes, sir. In fact, that was developed as Dr. Macdonald said earlier. It was actually developed through the task force process, which is exactly the way we are talking about doing this in the future as well.

Mr. **Hoyer**. Am I correct that only in the event that the contingency that was mentioned by Mr. Early, that is a cure was found and a decision was made that no further action on AIDS was necessary, would that spend out at the $143 million, $46 million and $13 million levels for those three entities not occur?

AIDS CURE—UNUSED FUNDS

Dr. **Dowdle**. To be honest, sir, we haven't discussed that. The likelihood of that happening is very small. It is a hypothetical question.

Mr. **Little**. I think technically we would have to come back to the Committee. If the Committee appropriated the $203 million for purposes for which we have asked and we found the cure for AIDS, we would in effect be at a point where we didn't need to spend a part of these resources for AIDS. If we elected not to spend these funds for AIDS, I believe we would come back to the Committee and propose a rescission, deferral, or a reprogramming and tell the Committee how we proposed to spend the money. This appropriation is for AIDS. In order for us not to spend that money, we would have to inform the Congress.

Mr. **Early**. If you will yield, the original question on the authorities said that under that, the intention is for AIDS but it could be used for other than AIDS. Originally you said that, didn't you, Dr. Macdonald?

Mr. **Little**. I accept that, legally.

Mr. **Early**. When you say "legally," multi-year funding.

Mr. **Hoyer**. You are being awful tough on OMB.

Mr. **Early**. No.

Mr. **Hoyer**. Dr. Stockman and Dr. Miller did great work in medical research over the years. I understand what you are saying about the suggestion that we are not going to cure AIDS this year and therefore the contingency set up by Mr. Early is not going to happen.

The point is, however, is there any contingency you can see where NIH would not get $143 million in fiscal 1987?

Dr. DOWDLE. No. At the same time, in the process that we now have set up, where we have frequent review of the PHS Plan for Prevention and Control of AIDS—when I say "we" I am talking about the entire task force, the entire Public Health Service, of which NIH is a part, CDC is a part, and ADAMHA is a part—if that group decided or recommended as a group that certain adjustments might be made in some of the funding to meet certain contingencies, then that recommendation would be made to Dr. Macdonald.

I would not see that as major changes. I think we are really talking about refinements in the plan as we go along. Something major would be handled in other ways.

The answer to the question about would they spend it, for all practical purposes, is yes.

CATASTROPHIC ILLNESS

Mr. HOYER. Dr. Macdonald, the President in his State of the Union indicated he was, and I understand he has instructed Secretary Bowen, to study catastrophic illness. I think all of us are concerned about that, the devastation that affects families when they are faced with catastrophic illness.

Am I correct that you have done studies and have much of the information that we will need for that study?

Dr. MACDONALD. Yes. Much of the data on health care comes out of the National Center that Dr. Marshall heads. The cost of delivery of medical care is one of the things they study regularly. Much of the data will come from the Public Health Service.

Mr. HOYER. Perhaps I could ask Dr. Marshall. How close are we to having the availability of such a report, which I presume is the compilation, analysis and comment on much of the information you have already collected. Is that correct or not?

Mr. MARSHALL. It is the report that the Department is working on now—we have promised to have it completed by next Fall. Much of it will be based on data that are available—that kind of timeframe is not going to allow for conducting new surveys. We will be in a better position when we have the national medical expenditures survey in 1988 and 1989 to update that. We will work from existing data now. We have funded a number of studies over the past decade that give us some sense of what the cost of catastrophic illness is, what percentage of the families are affected by it.

For example, we know that a relatively small percentage of families with high incomes spend as much as five percent of their discretionary income on health care, whereas for families in the lower income groups, about 33 percent of those families end up spending more than five percent of their total income on health care costs for the year.

We will be providing material for that analysis that looks not only at what is characterized as acute catastrophic illness but also at some of the kinds of things that affect the elderly population.

We have done surveys and supported studies that look at long term care activities.

In addition, the Center has carried out a great deal of analysis with respect to one of the other parts of the study, which is to look at what the opportunities are for private coverage for catastrophic issues including long term care.

We will be working closely with the groups that are carrying out that study across the Department. There will be lots of people involved. We will be one of the major sources of data for it.

Mr. HOYER. Who other than yourself will be involved in that study?

Mr. MARSHALL. I have put together a committee within the Center which includes about seven people. Five of them are intramural scientists and two are from our extramural research program. They are people who have been working on areas related to this. They are people from the staff who have expertise and have published in these areas and who, in addition to their own work, know the literature and know the people who are doing other work.

USER LIAISON PROGRAM

Mr. HOYER. Thank you. We will be interested in that study. Doctor, seeing that you are at the table, let me pursue one additional question with respect to this user liaison program that obviously Mr. Conte and I share an interest in and I am sure others do as well.

I haven't any doubt one of the reasons is because all the state legislatures have contacted us. They are a pretty potent constituency. They feel there has been some value to the program. In point of fact, your answer to the last question took your most expensive programs. You had 15 programs for less than $15,000. Most of these were in the $2,000 level in terms of the conference costs.

You took your most expensive example. If this Committee in effect reverses your action and it obviously has a very powerful ally. You don't have to worry about me. I am down here at the end. When you get Mr. Conte and Mr. Natcher interested in things, then you have to start thinking that maybe something will happen.

Have you put the program in a position where it cannot be in effect rehabilitated? Are these people gone and forgotten?

Mr. MARSHALL. No, sir. Those people are not gone and they are not forgotten. Again, I want to emphasize what I have said is not going to happen. I am not going to fund outside contractors this fiscal year. We are going to operate this as an in-house activity. It will involve more people within the Center, doing more things, but less of the very highly expensive things that require contractors to do—things which require paying their overhead and their profit and their administrative costs.

USER LIAISON CONTRACTORS

Mr. HOYER. It is tough dealing with the private sector, I guess. Contracting out is probably more expensive than keeping it inhouse.

Mr. **MARSHALL**. Sometimes it is more expensive to contract it out and sometimes, it is not. We are always doing A76 analyses before we make those determinations, Mr. Hoyer.

Mr. **HOYER**. I am hoping that we do keep things in-house and have our own folks perform these services. Who are the contractors that you are talking about? I may not have as good a grasp on who the contractors are.

Mr. **MARSHALL**. Right now, there have been three contractors that have been working with the program. One is an organization that is Lewin Associates.

Mr. **HOYER**. These are private sector contractors who put on these conferences?

Mr. **MARSHALL**. Yes, sir. One is the Alpha Center and one is an organization called Applied Management Sciences. They were all competitively selected.

Mr. **HOYER**. I can't speak for Mr. Conte. I haven't heard from any of those folks. All the people I have heard from are users, beneficiaries of the program as opposed to contractors.

I have some other questions, Mr. Chairman. It is getting late. I will submit them for the record. Thank you, Mr. Chairman.

Mr. **CONTE**. I have further questions but I will submit them for the record as well.

Mr. **NATCHER**. Dr. Macdonald, we want to thank you and your associates for appearing before our Committee at this time on behalf of your budget requests for fiscal year 1987. Doctor, this has been a good hearing and we appreciate it.

Dr. **MACDONALD**. Thank you very much, Mr. Natcher.

Mr. **CONTE**. When we were discussing Title X, I don't know if the stenographer heard you. You finally said you agreed with my interpretation.

Dr. **MACDONALD**. That's correct.

Mr. **CONTE**. Thank you very much.

Mr. **NATCHER**. The Committee will now adjourn until 10:00 a.m. in the morning.

[The following questions were submitted to be answered for the record:]

ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)

Mr. Natcher. The budget is proposing 1986 rescissions for AIDS totalling $41,075,000.

a) Why should we approve any further 1986 reductions for AIDS activities?

b) If Congress does not approve the rescissions, will you be able to expeditiously use these funds for worthwhile activities?

c) Specifically, how would you plan to utilize the remaining $15.3 million demonstration projects?

Dr. Macdonald. The $41 million proposed for rescission represents the funds remaining after scheduled sequestering related to $48 million for AIDS projects which Congress added to the budget in excess of the Administration's identified needs for AIDS activities for 1986. If Congress does not approve the rescissions, PHS would use the funds to expand ongoing AIDS activities in 1986. All of these funds would be obligated before September 30, 1986.

If the PHS request to have the $15.3 million demonstration projects rescinded is rejected, PHS will publish a notice of availability of funds to solicit proposals from the four Medical Service Areas (MSA) of highest concentration of those affected by AIDS to establish four demonstration projects. We would allow for the receipt of more than one application for consideration from each of the four MSAs. However, each MSA would receive a single grant. Greatest consideration would be given to those applicants who: (1) demonstrate a model that provides for a consortium approach to providing a continuum of services to AIDS patients that includes State/local health departments, clinics, hospitals, HMOs, and other community facilities; and (2) give consideration in their approach to contiguous areas (i.e., outside the MSA) with highest concentration of AIDS victims such as Belle Glade, Florida and Newark, New Jersey. In addition, greater consideration will be given to those applicants who demonstrate the greatest degree of coordination and support of local government and demonstrate involvement of appropriate community organizations concerned with AIDS patients.

The proposed grantees would be required to design a community-oriented system of care for AIDS patients which covers a continuum of care from diagnosis to chronic care.

Factors that will be considered in determining the specific allocation to each grantee include comprehensiveness of proposal, size of AIDS population and consideration given to special populations.

Mr. Natcher. We know that Dr. Dowdle from CDC was recently appointed temporary AIDS coordinator for the Public Health Service. Do you plan to name a permanent coordinator?

Dr. Macdonald. Yes. However, during the interim, the functions of the job will be carried out by a temporary AIDS coordinator.

7½% EVALUATION SET-ASIDE

Mr. Natcher. On page 2 of the justification, you show an amount of $4,666,000 for 'health services research 1 percent evaluation projects". Can you tell us where this money comes from and how it is used?

Dr. Macdonald. Section 2113 of the Public Health Service Act allows the Secretary to utilize up to 1 percent of the total discretionary grant and contract money for evaluation purposes. P.L. 98-551 amended Section 305(h) of the Public Health Service Act and directed the Department to provide 7.5 percent of the amount available under Section 2113 to be available "to conduct or support (by both grants and contracts) through the Center, evaluations of health services and health care technology which evaluations are not being conducted or supported under this Section or Section 304".

Mr. Natcher. Why do you have a $3 million increase in this from 1985 to 1986?

Dr. Macdonald. In FY 85, approximately $60,000,000 was available under the total set-aside. However, only $20,000,000 of these funds were used for evaluation purposes. Therefore, $1,507,000 was made available to NCHSR as 7.5 percent of amount used which was $20,000,000. P.L. 99-117 amended Section 305(h) to require that "In administering this subsection, the Secretary shall assure that the amount to be made available in any fiscal year is 7.5 percent of the maximum amount authorized to be made available under Section 2113 in such fiscal year." This had the effect of changing the base amount against which the 7.5 percent was applied to approximately $64,000,000. This resulted in an increase of $3 million for the amount set-aside under Section 305(h). After sequestration, this amounted to $4,666,000.

Mr. Natcher. Why shouldn't these funds be requested as part of the National Center's budget, instead of being earmarked in the law as a special setaside.

Dr. Macdonald. In the Committee report language which accompanied P.L. 98-551, the Congress indicated that because the appropriation action for FY 1985 was completed in advance of the authorization language which established additional responsibilities and the set-aside of funds for particular purposes for NCHSR, it was the intent of the Congress to supplement the funds available through the appropriation. The Department believes that funding for NCHSR should be part of the normal appropriations process rather than the result of assessments from other appropriations.

NATIONAL CENTER FOR HEALTH STATISTICS FY 1987 BUDGET INCREASES

Mr. Natcher. You're seeking an increase of $5,341,000 for the National Center for Health Statistics (NCHS). Why is this increase necessary?

Dr. Macdonald. The increase is necessary to support costs associated with the Health Examination and Vital Statistics programs. Approximately $3.0 million is requested for the National Health and Nutrition Examination Survey (NHANES) for costs of preparing for the data collection phase of the next cycle of this survey, which is scheduled to begin in 1988. The funds will be used to purchase diagnostic equipment, renovate mobile examination centers, develop data collection methods and laboratory contracts. Data is expected to be obtained from physical examinations of approximately 30,000 people over six years.

An increase of $2.3 million is requested for the National Vital Statistics System, to:

- restore the FY 1986 sequestered amount, allowing NCHS to resume the purchase of a full 12 month period of data from the States (due to the sequestration, the FY 1986 contract periods have been adjusted to achieve one-time cost savings);

- maintain the Federal share of the costs of this joint Federal-State system at approximately the current level of 25 percent; and

- acquire linked birth and infant death records from all States in order to provide needed data for an intensive investigation of the correlates of risk of prenatal and infant death.

REDUCTIONS IN THE FY 1986 NCHS BUDGET

Mr. Natcher. Your 1986 request for NCHS was reduced by the Congress by $2 million and reduced by Gramm-Rudman by an additional $2 million. Is that correct? What effect has this had on your original plans for 1986?

Dr. Macdonald. Yes, that is correct. The principal effect of the $2 million Congressional reduction is that the sample size of the National Health Interview Survey will be reduced to 50 percent of its planned level. This will mean that oversampling on certain subgroups of the population will be curtailed resulting in less information on minorities, the elderly, low income families, and persons with rare health conditions.

As a result of the FY 1986 sequestration, NCHS is adjusting the contract period with States in the National Vital Statistics System, through which the Federal government funds a share of the costs incurred by these States in producing vital statistics for national use (births, deaths, cause of death, infant mortality, etc.). Normally, a full 12 months of data are purchased each fiscal year; during FY 1986, however, data will only be purchased through the month ending December 31, 1986, resulting in a shorter contract for some States. This contract adjustment will result in one-time savings in FY 1986. NCHS will use approximately $2 million of the 1987 budget increase to fund each of those States for a full year at the end of their FY 1986 contracts, and there will be no effect on program operations.

NATIONAL NUTRITION MONITORING SYSTEM

Mr. Natcher. On page 32 of the justification, you mention the National Nutrition Monitoring System. Can you describe this system for us and tell us how it is funded?

Dr. Macdonald. The National Nutrition Monitoring System (NNMS) was developed by the Departments of Health and Human Services and Agriculture in the late 1970's in response to Congressional interests expressed by the House Committees on Agriculture and Science and Technology. The purpose of the System is to provide, in a coordinated set of programs, for the development of basic information necessary to examine the linkages between food consumption patterns, nutritional status and health status. The uses of the System's information are to ensure the nutritional quality of the national food supply, to ensure the nutritional needs of the population are being met, and to ensure data bases are maintained to guide the expenditure of public funds for nutrition research and for development of education and intervention programs to maintain or improve the nutritional status of the population.

Information sources for the NNMS are found in the National Center for Health Statistics (NCHS), the Food and Drug Administration, the Centers for Disease Control, the Health Resources and Services Administration, the National Institutes of Health, and agencies of the U.S. Department of Agriculture. In NCHS, a number of programs are considered parts of the NNMS. The National Health and Nutrition Examination Survey (NHANES) is viewed as its cornerstone. It uniquely provides information on the nutritional status of the population, and measures of nutritional status can be related to food consumption patterns and health variables. In addition, the information from the National Vital Statistics program, the National Health Interview Survey, and other NCHS programs make significant contributions to analysis of nutrition-related issues. Some examples are numbers of low birth weight infants, uses of dietary supplements, and food habits.

Each program of the NNMS is funded separately as part of its agency's normal appropriation process; for example, a large portion of the increase in the FY 1987 request for NCHS is to provide funding necessry for the next National Health and Nutrition Examination Survey. Justifications of the individual components of NNMS usually refer to relationships to the System, but also refer to their importance independent of the System.

SMOKING AND HEALTH ACTIVITIES

Mr. Natcher. For the record, provide the usual table showing smoking and health funds by agency for fiscal 1985 to 1987.

Dr. Macdonald. The Public Health Service will be spending approximately $45.2 million in 1987 to combat smoking and understand its destructive effects on health. The majority of these expenditures are within the National Institutes of Health and are primarily in support of direct biomedical research on the health consequences of smoking. Other principal participants are the Office on Smoking and Health, the Alcohol, Drug Abuse and Mental Health Administration, and the Centers for Disease Control.

(dollars in $000)

	FY 1985 Actual	FY 1986 Revised	FY 1987 Request
NIH			
Cancer	$21,131	$23,284	$24,713
Heart, Lung & Blood	10,375	10,465	10,141
Environmental Health	519	517	503
Child Health	1,316	1,300	1,300
Research Resources	730	717	652
NIH, Subtotal	(34,071)	(36,283)	(37,309)
ADAMHA			
Drug Abuse	4,364	3,535	3,641
OASH			
Smoking and Health	3,531	3,375	3,471
CDC			
Chronic & Environmental Health	375	755	755
PHS Total	$42,341	$43,948	$45,176

Mr. Natcher. What is the purpose of the national advisory committee on smoking and health?

Dr. Macdonald. The Interagency Committee on Smoking and Health is a national advisory committee which advises the Secretary, Department of Health and Human Services, on a wide range of issues pertaining to the smoking and health issue. Specifically, the Committee is charged with coordination of research and education programs and maintenance of liaison with appropriate Federal and non-Federal agencies relating to smoking and health. The Committee consists of 22 members and is chaired by the Surgeon General, Dr. C. Everett Koop. Five of the members are scientists or physicians who represent private entities involved in informing the public about the health effects of smoking. The remaining 17 members represent various Federal agencies.

Mr. Natcher. Is this a statutory advisory committee?

Dr. Macdonald. The Interagency Committee on Smoking and Health is required by the Comprehensive Smoking Education Act of 1984 (P.L. 98-474).

Mr. Natcher. On page 43 of the justification, you mention a "nutrition initiative" in connection with disease prevention and health promotion. Can you explain this in a little more detail?

Dr. Macdonald. The Nutrition Initiative works to strengthen the Department's capabilities and national leadership in nutrition research, monitoring, services and training, and education as well as in food safety and quality. The primary vehicle for this is the

Department's Nutrition Policy Board, staffed by the Office of Disease Prevention and Health Promotion.

The major single project of the Nutrition Initiative in FY 1986 is preparation of The Surgeon General's Report on Nutrition and Health. The report's primary objective is to provide policymakers and health care providers with a reveiw of the science base for the key issues in nutrition and health. Specifically, the report will:

- identify the main nutritional issues related to public health and make statements about their current status in the U.S. population and their relative importance to disease prevention and health promotion efforts in the nation. As an example, impressive evidence suggests that dietary factors are important components of four of the ten leading causes of death in this country: coronary artery disease, stroke, cancer and diabetes. Prominent dietary factors are also involved in issues relevant to pregnancy and infant health, aging, and dental caries.

- estimate the strength of association between health and various nutritional factors using the most recent state-of-the-art research insights.

- focus on the identification, discussion, and documentation of the key scientific issues important to the formulation of current nutrition policy and recommendations for the public. The report will not make definitive or final judgments regarding nutrition and health.

The revised first draft of the Report is currently under review. Two additional comprehensive reviews are planned. Drafts of the chapters will undergo extensive peer review by Federal and non-Federal experts in the area of nutrition. In addition to PHS agency review and clearance and technical editing and review by the Nutrition Policy Board, the Report is being reviewed by approximately 120 nutrition scientists from all areas of the nutrition field.

Coordination between the Department of Health and Human Services and the Department of Agriculture is another important part of the Nutrition Initiative. This collaboration is frequent and extensive, as illustrated by the following examples related to specific components of the initiative.

o Nutrition research - An Interagency Committe on Human Nutrition Research (ICHNR) has been established, co-chaired by the responsible Assistant Secretaries at the Department of Agriculture and the Department of Health and Human Services. The committee meets quarterly and has representation from seven agencies and departments within the Federal government. The ICHNR is currently involved in an extensive review of nutrition research activities in the Federal government and is in the process of developing a five year plan for those efforts. The five year plan for nutrition research is scheduled for release in the Spring 1986.

o Nutrition monitoring - A Joint Nutrition Monitoring Evaluation

Committee, co-chaired by the responsible Assistant Secretaries in the two Departments, was established to review our respective activities in nutrition surveillance and monitoring, and to develop periodic reports on the nutritional status of the American people. A first comprehensive report is nearing completion and is scheduled for release in Summer 1986.

- Nutrition education - Meetings are held regularly to discuss issues of nutrition services and nutrition education. The USDA/DHHS Nutrition Education Committee for Maternal and Child Nutrition Publications provides an example of such collaboration. This committee seeks to assure that consistent messages about maternal and child nutrition are provided to the public. The annual symposium recognizing National Nutrition Month held March 21, 1986, addressed the Federal nutrition research plans.

- Food safety and quality - The two Departments have formal and informal relationships to discuss issues of food safety and quality on a regular basis with emphasis on improving the Federal contribution in this regard.

Mr. Natcher. Do we have a problem in this country with severe malnutrition in some localities?

Dr. Macdonald. Available evidence suggests that cases of severe malnutrition--undernutrition--can be identified in this country but are isolated and individual rather than prevalent as patterns throughout whole communities. Even though severe clinical malnutrition is not generally considered a major public health problem in the U.S., any such event is cause for vigorous remedial action. A much more prevalent nutritional problem for Americans--including low income Americans--is found in the health conditions associated with eating too much food or with eating an improper balance of foods.

EVALUATION FUNDS

Mr. Natcher. How much money will the Public Health Service spend in 1986 for the so-called 1 percent evaluation set aside?

Dr. Macdonald. The total amount of Public Health Service funds that will be spent in 1986 is estimated at $24 million. Of that amount, the Office of the Secretary will spend $7.3 million; the Office of the Assistant Secretary for Health, $3.6 million; the various PHS agencies, $8.4 million; and $4.7 million has been allocated to the National Center for Health Services Research, pursuant to P.L. 98-551 and P.L. 99-117.

Mr. Natcher. How do you use these funds each year?

Dr. Macdonald. The 1 percent evaluation funds are used to evaluate the effectiveness of the various health programs, policies, and functions for which PHS and DHHS are responsible.

Mr. Natcher. For the record, provide a table showing the agency utilization of these funds for 1985 and 1986.

Dr. Macdonald. The following table reflects the amounts used by the various PHS agencies and the Department to evaluate their programs.

Fiscal Year 1985 1% Evaluation Funds

	Assistant Secretary for Planning and Evaluation/DHHS	Assistant Secretary for Health	PHS Agencies	OASH/NCHSR P.L. 98-551 7½ Percent	Total Evaluation
HRSA	$607,500	$414,400	$2,388,211	$347,900	3,758,011
CDC	181,900	124,950	513,008	61,600	881,458
NIH	3,687,000	2,648,100	2,200,000	917,000	9,452,100
ADAMHA	290,200	197,750	1,277,000	159,300	1,924,250
OASH	169,000	114,800	---	21,200	305,000
Total	$4,935,600	$3,500,000	$6,378,219	$1,507,000	$16,320,819

Fiscal Year 1986 1% Evaluation Funds

	Assistant Secretary for Planning and Evaluation/HHS	Assistant Secretary for Health	PHS Agencies	OASH/NCHSR P.L. 98-551 P.L. 99-117 7½ Percent	Total Evaluation
HRSA	$629,500	$316,800	$2,766,400	$408,000	4,120,700
CDC	301,200	149,500	785,000	191,000	1,426,700
NIH	5,766,200	2,844,900	3,000,000	3,650,000	15,261,100
ADAMHA	411,800	204,400	1,838,000	263,000	2,717,200
OASH	246,400	121,000	---	154,000	521,400
Total	$7,355,100	$3,636,600	$8,389,400	$4,666,000	$24,047,100

Mr. Natcher. In page 49 you mention an increase of $848,000 to restore certain items that were deferred in 1986 in your management budget activity. Why do you need to restore these items in 1987.

Dr. Macdonald. The increase in 1987 is needed to fund:

o The full-year costs of salaries and related expenses for positions that were vacant or occupied for only part of the year in FY 1986. These include the Assistant Secretary for Health and a Regional Health Administrator. Filling of several other positions in 1986 was delayed in order to meet the Gramm-Rudman-Hollings reduction in 1986.

- The full-year cost of promotions and within-grade increases. These actions were delayed in 1986 to recoup a one-time dollar savings to meet the Gramm-Rudman-Hollings reduction. Many of these actions will be effective for only a few months in 1986 but will require a full 12 months funding in 1987.

- Purchases of office automation equipment which was deferred from 1986 to 1987. There is heavy reliance on automated equipment as a result of past staffing reductions.

- Resumption of planned travel for staff to conduct site visits, attend meetings and conferences, review PHS properties, and other functions where representation by the Assistant Secretary for Health, the Surgeon General and others would be expected. Travel was reduced by 41 percent in 1986. Since the position of Assistant Secretary for Health was vacant in 1986, the travel by the Acting Assistant Secretary was much less. Therefore, a resumption of travel for a permanent ASH is anticipated.

- Resumption of training that was deferred in FY 1986. Training for personnel specialists, EEO managers, and others where currency of law is critical will be resumed as well as training to enhance the ability of employees to assume additional and different responsibilities. As we continue to automate, our training needs will increase. However, there will be a long-term savings in terms of increased productivity.

- Built-in increases, including with-in grade increases and utility and telephone costs.

Mr. Natcher. On page 4 you show a proposed reduction of $413,000 for "management savings" in 1987. How was that figure calculated?

Dr. Macdonald. The figure is an estimate of management savings that should result from several administrative cost saving measures. For example, a centralized travel service is saving money in terms of staff time and in some cases, the travel cost. Another example is the use of personal computers which enable us to do things in-house which we have previously paid contractors to do.

OASH TRAVEL INCREASE

Mr. Natcher. You show on page 7 a proposed increase for travel costs of nearly $500,000 (30 percent). Why is this necessary?

Dr. Macdonald. Page 7 of the FY 1987 budget request for the Office of the Assistant Secretary for Health (OASH) was revised subsequent to its submission to Congress. Correction pages were delivered to members of the House and Senate Committees on Appropriations prior to the appropriations hearings.

We are requesting $1,863,000 for travel within the Public Health Service management appropriation in FY 1987. This represents an increase of $385,000 or 26 percent over the 1986 level (after sequestration) of $1,478,000. The increased travel costs are associated with three surveys being conducted by the National

Center for Health Statistics (NCHS). Included in the increase are funds for field pretests for the National Health and Nutritional Examination Survey (NHANES) and the National Survey of Family Growth (NSFG), and onsite data collection activities associated with the National Health Interview Survey Cancer Supplement. The increase also reflects restoration of the 1986 level of effort for PHS management activities prior to sequestration.

Mr. Natcher. How much was spent in 1985 from this account for travel to meetings and conferences?

Dr. Macdonald. FY 1985 actual obligations for travel associated with information meetings and conference attendance totaled $525,000 from funds directly appropriated to the Public Health Service Management account.

RETIREMENT PAYMENTS

Mr. Natcher. What was the average annual retirement payment for the Retired Pay account in 1985?

Dr. Macdonald. The average annual retirement payment in Fiscal Year 1985 was approximately $27,882 for retirees and $10,429 for survivors.

EVALUATION FUNDS

Mr. Roybal. Please indicate the amount of dollars and percent of the PHS budget allocated for evaluation studies since 1980 and the amount and percent proposed for 1987.

Dr. Macdonald. The percentage of PHS funds spent each year for evaluation of programs is considerably less than the maximum of one percent that can be used for evaluation under Section 2113 of the PHS Act. The amounts allocated from PHS budgets for evaluation studies since 1980 are as follows:

1980	$22,576,000
1981	21,461,000
1982	19,256,000
1983	23,014,000
1984	21,002,200
1985	21,601,600 *
1986 est	24,047,000 *
1987 est	24,047,000 *

* These amounts reflect a newly enacted law to provide 7.5 percent of the one-percent to the National Center for Health Services Research/HCTA. This increased the total amount.

Mr. Roybal. Please also indicate which studies were funded with these monies during 1986 and, similarly, how they will be allocated in 1987.

Dr. Macdonald. Final decisions have not been made yet on the specific evaluation projects that will be funded in 1986, and plans for 1987 are just getting underway. However, the following provides examples of the kinds of studies that were funded in FY 1985 by the PHS agencies.

Health Resources and Services Administration

Analysis of Physician Indebtedness and Characteristics That Relate to Career Preference.

This study, being done by the Association of American Medical Colleges, will analyze medical student indebtedness, sociodemographic characteristics and the impact on career plans. Of particular interest is the impact of debt on choice of specialization, and whether there are extensive shifts from the primary care specialities, to non-primary care specialities. Initial findings are that high indebtedness is associated with a tendency to choose residency training in the non-primary care specialities, and to prefer an urban or suburban practice location.

Assessment of the Potential Organ Donor Pool

This study is being done in two phases for the Advisory Committee of the National Task Force on Organ Transplantation. Phase One made an assessment of the estimates of the potential donor pool found in the published literature. It was concluded that these studies did not provide a sound basis for making an accurate estimate of the national organ donor pool for all five organ systems of interest to the Task Force. Phase two assessed the reliability of an estimate of the number of cadaveric organ donors available in the U.S.

Centers for Disease Control

Evaluation of the Epidemiologic Surveillance Project

This study is to evaluate whether data collected for the Morbidity and Mortality Weekly Report and the annual summary of reported morbidity and mortality in the U.S. via computers from State health departments to CDC is as timely, effective, accurate, and cost beneficial as reports received through the mail and telephone systems.

National Institutes of Health

A Study of Models for Biomedical Research

This study examined the utility and potential applicability of many alternative approaches to improving understanding of human biological and behavorial systems. The study committee spelled out the conditions under which alternative models should be selected, and recommended wider use of nonmammalian organisms, cell and tissue culture systems, and mathematical models, especially in the early stages of investigation of specific problems.

Alcohol, Drug Abuse, and Mental Health Administration

Evaluation of Selected Areas of NIDA's Research Program

This project convened a group of drug abuse researchers to evaluate four years of NIDA's research program in areas of behavioral pharmacology, abuse liability, and prevention and treatment for young people. The objective of the evaluation was to design comprehensive approaches to short and long-term research goals based on achievement in these areas, the current state-of-the-art technology and potential for achieving significant break throughs as well as to identify and resolve related administrative and policy issues.

In addition, following is a listing of several other on-going evaluation studies:

Analytical Policies-Division of Health Care Statistics
Evaluation of HANES Non-Response Bias
Integration of NCHS Programs
Evaluation of Data Dissemination and Data Use
Surveys of Medicaid Beneficiaries
Hospital Cost and Utilization Project
Payment System on Clinical Cancer Research
Healthy Older People Public Education Program
Physical Fitness Status of American School Children
Evaluation of Forecasting Methods of PHS and Others
PHS Policies with State and Local Health

Explore Issues of Access and Quality of Care
Research and Development Automated HHS Data Inventory
PHS Debt Management Initiatives
Medical Malpractice in the 1980's

NATIONAL MEDICAL EXPENDITURE SURVEY

Mr. Roybal. It is our understanding that a total of $16 to 20 million are required in 1987 to fully fund the National Medical Expenditures Survey (NMES) - including the new portion of the survey on expenditures for nursing home care and for the mentally retarded. What are the projected costs for NMES in 1987, 1988 and 1989? Given that only $3 million has been proposed in NCHSR's 1987 budget for NMES, how do you propose to make up the difference? Will there be a funding shortfall and if so, what impact will this have on the schedule or scope of NMES?

Dr. Macdonald. Projected costs for NMES, including the institutionalized population component (IPC) which will survey residents of nursing homes, psychiatric hospitals and intermediate care facilities for the mentally retarded, are: $22,150,000 in FY 1987; $13,300,000 in FY 1988; and $6,500,000 in FY 1989. NCHSR is working with other programs within the Department including HCFA, the National Institute of Mental Health and the Indian Health Service, to arrange for financial support of those sections of the survey which bear heavily on their missions. The level of these commitments, however, remains uncertain. In the event that NCHSR is unable to obtain sufficient funding to conduct all components of the survey, the Center will have to re-assess the scope of the survey.

VARIATIONS IN MEDICAL CARE

Mr. Roybal. What is the current status of proposed NCHSR studies on variations in the use of medical care by disadvantaged groups and on factors differentiating high and low users of medical care among the elderly? What are the objectives of these two studies?

Dr. Macdonald. A recently completed NCHSR-funded study reveals substantial variations in access to health care among mainland Puerto Ricans, Mexican-Americans, and Cuban-Americans--the three ethnic groups representing the majority of the Nation's more than 14 million Hispanics. The study shows that Mexican-Americans have the worst access to health care of the three groups: they are least likely to see a doctor during the year and those who do average the lowest number of visits. Mexican-American children are especially affected: only slightly more than half see a doctor during the year. By contrast, roughly two-thirds of Cuban-American and black, non-Hispanic children see a doctor each year, as do three-quarters of the children of Puerto Ricans and white, non-Hispanics. Puerto Ricans are the most likely of the three ethnic groups to visit a doctor, and do so more often than other Hispanics and non-Hispanics. Cuban-Americans, the wealthiest and best educated of the three groups, have physician-use rates similar to those of white, non-Hispanics. This study is one of the first to compare the medical care access of Hispanic ethnic groups, as well as that of white and black non-Hispanics.

The second study, which is examining factors differentiating high and low users of medical care among the elderly, was begun during Fiscal Year 1985 and is currently in the data collection stage. The objective of the study is to conduct a descriptive longitudinal analysis of the patterns of ambulatory care use by aged members of Kaiser's Portland (Oregon) plan to determine what factors differentiate consistently high and low users of services.

High and low users are identified as individuals falling into the highest and lowest percentile of medical contacts during a given year. The analysis focuses on the differences in services and procedures for consistently high and low users, the relative values and costs of procedures, comparisons of high and low users' reasons for seeking care, socio-economic characteristics, differences in health status, health practice and habits, as well as place of service. Data sources include two five percent samples selected randomly from the HMO population in 1971 and 1981 for a total over 65 population of 829, and the Kaiser outpatient system.

EFFECT OF BUDGET PROPOSALS ON SCOPE OF PLANNED STUDIES

Mr. Roybal. Were any of the major NCHS or NCHSR studies, or will they be, significantly modified in terms of sample size, measures to be included, or time frame for completion of data gathering or data analysis as a result of sequestration or the 1987 budget request? If so, what impact will these modifications have on the usefulness of these studies?

Dr. Macdonald. For the National Center for Health Statistics (NCHS), there are three modifications:

- o Funding is not included in the FY 1987 request for the conduct of the previously planned 1988 National Ambulatory Medical Care Survey (NAMCS). As a result, this survey will be delayed at least one year. The NAMCS collects information about ambulatory medical care provided by office-based physicians, including the demographic characteristics of patients and the services provided (diagnosis, diagnostic procedures, drugs prescribed, patient management, planned future treatment, etc.).
- o Based on the funding levels in the FY 1987 request, the sample size of the 1988 National Health and Nutrition Examination Survey (NHANES) will be 30,000 persons, rather than the 40,000

that had initially been planned. The principal impact of this change will be less oversampling of certain subgroups of the population which will affect the timeliness and precision of estimates for blacks and Hispanics. The NHANES collects nutritional, physiological, and diagnostic data through specially designed standardized health examinations, including clinical tests and measurements.

- As a result of the FY 1986 sequestration, NCHS is adjusting the contract period with the States in the National Vital Statistics System, through which the Federal government funds a share of the costs incurred by those States in producing vital statistics for national use (births, deaths, cause of death, infant mortality, etc.). Normally, a full 12 months of data are purchased each fiscal year; during FY 1986, however, data will only be purchased through the month ending December 31, 1986, resulting in a shorter contract for some States. This contract adjustment will result in one-time savings in FY 1986. NCHS will use approximately $2 million of the 1987 budget increase to fund each of those States for a full year at the end of their FY 1986 contracts, and there will be no effect on program operations.

SURVEYS ON HEALTH CARE EXPENDITURES

Mr. Roybal. From analyses of recent studies, what are the latest figures for health care cost for those under 65 and for those over 65 by source of funds (Medicare, Medicaid, other governmental programs, out-of- pocket, insurance, Medicare premiums, and other private sources) and type of care (hospital, physician, nursing home, home health, and other care). For those over 65, please provide the data by 5 year age increments.

Dr. Macdonald. You asked for the latest figures for health care costs for those under 65 and those over 65 by source of funds and type of care. The following four tables containing estimates from the National Medical Care Utilization and Expenditure Survey (NMCUES). That survey, sponsored by the National Center for Health Statistics (NCHS) and the Health Care Financing Administration in 1980, estimated that health expenditures for the civilian noninstitutionalized population amounted to $211.9 billion and that $156.3 billion (including overpayments caused by multiple payments for the same service) was paid by the various sources of payment.

BLANK PAGE

BLANK PAGE

BLANK PAGE

TABLE 1

Total charges for all health services, by source of payment and type of health care coverage and type of health service: United States, 1980
(Civilian noninstitutionalized population)

Health care coverage and type of health service	All sources[1]	Out of pocket	Private[2]	Medicaid	Medicare	Other public program[3]	Other[4]
	Amount in millions						
All persons							
All services	$154,324	$42,927	$60,329	$13,045	$23,990	$10,306	$3,727
Ambulatory visits[5]	37,358	14,157	12,767	3,076	3,518	2,947	893
Hospital admissions[6]	87,567	9,684	40,538	8,476	20,183	6,631	2,056
Prescribed medications	7,988	5,158	1,603	695	91	323	117
Dental and other[7]	21,411	13,928	5,421	797	199	405	660
Under 65 years							
All services	115,137	35,200	54,075	10,016	3,109	9,397	3,324
Ambulatory visits[5]	30,778	12,003	11,970	2,537	657	2,748	864
Hospital admissions[6]	59,372	7,279	35,541	6,366	2,402	6,071	1,772
Prescribed medications	5,697	3,602	1,281	441	16	276	81
Dental and other[7]	19,289	12,316	5,282	672	33	362	624
65 years and over							
All services	39,187	7,727	6,255	3,029	20,882	909	385
Ambulatory visits[5]	6,579	2,154	797	539	2,860	200	29
Hospital admissions[6]	28,195	2,405	4,998	2,110	17,780	619	283
Prescribed medications	2,291	1,556	322	255	75	47	36
Dental and other[7]	2,291	1,612	138	125	166	43	36

TABLE 1 FOOTNOTES

[1] Charges calculated by source of payment include overpayments, i.e., reported payments from all sources for a given service may exceed reported charges for that service. Therefore, estimated total charges calculated by source of payment ($154.3 billion) are greater than estimated total charges calculated by reported charges ($153.9 billion).

[2] Includes Health Maintenance Organizations.

[3] Includes programs related to military service, Workers' Compensation, Indian Health Service, and other Federal, State or local government programs.

[4] Includes charges paid by provider or other sources and unknown sources.

[5] Includes all outpatient physician services, nonphysician services provided under the supervision of a physician, and the services of other independent health professionals, such as chiropractors, podiatrists, optometrists, psychologists, social workers, nurses, physical therapists, and others.

[6] Includes inpatient physician services.

[7] Includes dental care, eyeglasses, orthopedic appliances, hearing aids, diabetic supplies, and ambulance services.

TABLE 2

Total charges for all health services for persons under 65 years of age, by source of payment and type of health care coverage and type of health service: United States, 1980
(Civilian noninstitutionalized population)

Health care coverage and type of health service	All sources[1]	Out of pocket	Private[2]	Medicaid	Medicare	Other public program[3]	Other[4]
	Amount in millions						
All persons							
All services	$115,137	$35,200	$54,075	$10,016	$3,109	$9,397	$3,324
Ambulatory visits[5]	30,778	12,003	11,970	2,537	657	2,748	864
Hospital admissions[6]	59,372	7,279	35,541	6,366	2,402	6,071	1,772
Prescribed medications	5,697	3,602	1,281	441	16	276	81
Dental and other[7]	19,289	12,316	5,282	672	33	362	624
Private							
All services	73,417	24,295	45,830	275	7	1,012	1,998
Ambulatory visits[5]	19,653	8,493	10,239	4	4	372	540
Hospital admissions[6]	35,401	3,759	29,759	268	2	589	1,024
Prescribed medications	3,568	2,411	1,102	1	-	10	45
Dental and other[7]	14,794	9,633	4,729	2	-	41	389
Public							
All services	14,014	1,409	155	6,581	1,652	4,015	202
Ambulatory visits[5]	3,405	352	30	1,698	185	1,117	23
Hospital admissions[6]	8,811	507	121	4,051	1,437	2,545	150
Prescribed medications	730	207	2	345	7	158	11
Dental and other[7]	1,067	343	2	486	22	195	18
Mixed							
All services	15,011	3,060	5,487	1,488	1,438	3,188	351
Ambulatory visits[5]	4,109	967	1,135	420	463	1,048	75
Hospital admissions[6]	8,586	776	3,857	906	959	1,931	157
Prescribed medications	761	425	159	61	8	99	10
Dental and other[7]	1,555	892	336	101	7	109	110

Table 2, continued

Health care coverage and type of health service	All sources[1]	Out of pocket	Private[2]	Medicaid	Medicare	Other public program[3]	Other[4]
	Amount in millions						
Part-year							
All services	8,843	3,489	2,449	1,666	7	920	311
Ambulatory visits[5]	2,418	1,210	527	415	-	164	102
Hospital admissions[6]	4,854	1,156	1,696	1,136	4	731	132
Prescribed medications	401	334	17	34	-	9	7
Dental and other[7]	1,169	790	209	81	2	15	71
None							
All services	3,853	2,946	156	6	6	262	479
Ambulatory visits[5]	1,193	980	38	-	4	47	124
Hospital admissions[6]	1,720	1,081	110	5	-	214	309
Prescribed medications	236	227	-	-	-	-	9
Dental and other[7]	704	658	7	-	2	1	36

[1] Charges calculated by source of payment include overpayments, i.e., reported payments from all sources for a given service may exceed reported charges for that service. Therefore, estimated total charges calculated by source of payment ($115.1 billion) are greater than estimated total charges calculated by reported charges ($114.7 billion).

[2] Includes Health Maintenance Organizations.

[3] Includes programs related to military service, Workers' Compensation, Indian Health Service, and other Federal, State, or local government programs.

[4] Includes charges paid by provider or other sources and unknown sources.

[5] Includes all outpatient physician services, nonphysician services provided under the supervision of a physician, and the services of other independent health professionals, such as chiropractors, podiatrists, optometrists, psychologists, social workers, nurses, physical therapists, and others.

[6] Includes inpatient physician services.

[7] Includes dental care, eyeglasses, orthopedic appliances, hearing aids, diabetic supplies, and ambulance services.

TABLE 3

Total charges for all health services for persons 65 years of age and over, by source of payment and type of health care coverage and type of health service: United States, 1980
(Civilian noninstitutionalized population)

Health care coverage and type of health service	All sources[1]	Out of pocket	Private[2]	Medicaid	Medicare	Other public program[3]	Other[4]
	Amount in millions						
65 years and over							
All services	$ 39,187	$ 7,727	$ 6,255	$ 3,029	$20,882	$ 909	$ 385
Ambulatory visits[5]	6,579	2,154	797	539	2,860	200	29
Hospital admissions[6]	28,195	2,405	4,998	2,110	17,780	619	283
Prescribed medications	2,291	1,556	322	255	75	47	36
Dental and other[7]	2,291	1,612	138	125	166	43	36
Medicare Only							
All services	4,014	1,258	609	12	2,672	1	61
Ambulatory visits[5]	678	368	3	1	292	1	13
Hospital admissions[6]	2,845	445	8	10	2,343	-	39
Prescribed medications	280	263	-	-	10	-	6
Dental and other[7]	211	182	-	-	26	-	2
Medicare and private							
All services	27,827	5,724	5,953	388	14,892	611	259
Ambulatory visits[5]	4,764	1,576	758	67	2,212	135	16
Hospital admissions[6]	19,822	1,668	4,744	268	12,537	412	194
Prescribed medications	1,643	1,183	316	43	47	27	27
Dental and other[7]	1,598	1,298	135	10	96	37	22

Table 3, continued

Health care coverage and type of health service	All sources[1]	Out of pocket	Private[2]	Medicaid	Medicare	Other public program[3]	Other[4]
	Amount in millions						
Medicare and public							
All services	6,705	489	124	2,538	3,310	262	53
Ambulatory visits[5]	979	148	-	428	356	36	-
Hospital admissions[6]	5,267	195	123	1,791	2,900	208	49
Prescribed medications	308	67	1	196	18	15	3
Dental and other[7]	243	79	-	114	43	3	1
Other or none							
All services	561	256	166	91	-	36	12
Ambulatory visits[5]	159	63	35	33	-	27	-
Hospital admissions[6]	261	97	123	41	-	-	-
Prescribed medications	69	43	5	16	-	5	-
Dental and other[7]	72	53	3	1	-	3	11

---

[1] Charges calculated by source of payment include overpayments, i.e., reported payments from all sources for a given service may exceed reported charges for that service. Therefore, estimated total charges calculated by source of payment ($39.19 billion) are greater than estimated total charges calculated by reported charges ($39.16 billion).

[2] Includes Health Maintenance Organizations.

[3] Includes programs related to military service, Workers' Compensation, Indian Health Service, and other Federal, State, or local government programs.

[4] Includes charges paid by provider or other sources and unknown sources.

[5] Includes all outpatient physician services, nonphysician services provided under the supervision of a physician, and the services of other independent health professionals, such as chiropractors, podiatrists, optometrists, psychologists, social workers, nurses, physical therapists, and others.

[6] Includes inpatient physician services.

[7] Includes dental care, eyeglasses, orthopedic appliances, hearing aids, diabetic supplies, and ambulance services.

945

TABLE 6

Total health expenditures by type of expenditure and age: United States, 1980

[Civilian noninstitutionalized population]

	Total	Hospital stays	Inpatient doctor visits	Hospital outpatient department	Emergency room	Physician visits	Other visits	Other medical expenses	Prescribed medicines	Dental visits
All	$153,670	$71,055	$15,183	$6,080	$4,800	$20,605	$5,427	$3,710	$7,835	$17,001
Age										
Under 5 years	6,720	3,085	400	370	503	1,160	63	60	298	197
5-14 years	9,331	1,639	400	303	620	1,837	677	270	310	3,777
15-24 years	21,600	6,130	1,575	751	677	2,576	630	529	626	3,631
25-34 years	22,545	9,500	2,000	1,081	726	3,400	1,075	695	707	3,080
35-44 years	15,812	6,401	1,497	733	481	2,335	779	675	758	2,690
45-54 years	16,781	6,837	1,553	800	377	2,460	760	527	1,181	2,751
55-64 years	22,860	11,016	2,230	1,302	387	2,753	595	527	1,607	1,767
65-74 years	21,260	11,542	2,757	630	297	2,511	405	510	1,276	519
75-84 years	11,130	6,972	1,676	310	173	1,280	360	317	711	301
85 years and over	2,705	2,037	185	48	33	160	148	61	173	57

ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)

Mr. Roybal. Will the current commitments for AIDS research money be honored in spite of the consolidation of funds in OASH? Will the AIDS grants be subjected to the same level of downward negotiation that is proposed for other areas of research?

Dr. Macdonald. Yes, the current proposal contained in the consolidated AIDS account in the OASH activity represents our highest AIDS research and prevention priorities, and PHS plans to honor these commitments. The AIDS grants will be fully funded based on historical downward negotiations.

Mr. Roybal. Under this new funding consolidation plan, what process will be instituted to insure that funding plans are made on a priority basis and that all the agencies concerned have adequate input into the decision process?

Dr. Macdonald. In 1985, a comprehensive PHS Plan for the Prevention and Control of AIDS was developed by the AIDS Executive Task Force. This Plan was developed based on input from all the agencies concerned with AIDS research. Both the revised FY 1986 and the FY 1987 budgets were formulated based on the priorities set forth in the Plan.

Mr. Roybal. What program priorities have been articulated by the AIDS Coordinator and how does the [illegible] funding plan reflect these priorities?

Dr. Macdonald. The AIDS program priorities were not articulated by the AIDS Coordinator, but both the budget and funding plans were based on the priorities as contained in the PHS Plan for the Prevention and Control of AIDS. Some of the major program priorities and objectives include:

- Expand research efforts to develop effective therapies and a vaccine;
- Implement a major public education effort to encourage behavioral changes; and
- Continue efforts to clarify the epidemiology and natural history of the disease.

Mr. Roybal. How much of the 1987 projected funding for AIDS will be allocated to the agencies for current and new commitments, and how much would be held in reserve at the OASH level for a portion of the year to take advantage of new research opportunities?

Dr. Macdonald. All of the 1987 projected funding for AIDS will be allocated to the agencies, and none will be held in reserve at OASH. The current allocation plan is: NIH, $[illegible] million; CDC, $[illegible] million; ADAMHA, $[illegible] million; and OASH, $[illegible] million. Of the total, $[illegible] million will be for current commitments and $[illegible] million for new commitments.

Mr. Roybal. If the requested authority is approved, under what conditions and after what kind of decision-making process would the authority be invoked to move 1% of funding from lower priority programs to AIDS research and control? Are all programs within PHS vulnerable to this transfer, or would some be protected?

Dr. Macdonald. If a scientific breakthrough or a research opportunity is identified that would require immediate attention and/or an increase of AIDS research resources, the Secretary would invoke the authority (if approved) to transfer funds. All programs would be vulnerable to this transfer, however, only lower priority activities would be affected.

The responsibility of identifying any changes in research priorities lies with the PHS agencies and the PHS Executive Task Force. In response to any changes in research priorities the Task Force would review specific agency proposals necessary to address the new priorities, and make recommendations to the Assistant Secretary of Health (ASH). The Secretary, with advise from the ASH, would ultimately be responsible for making the determination to transfer resources to the AIDS account from lower health priorities.

Mr. Roybal. What is the exact impact of sequestration on any given agency's ability to move ahead on AIDS? Will appropriated monies in fact be released, and if so when, if Congress declines to approve the rescissions? Who is making the decisions in this regard, OMB or the individual agencies?

Dr. Macdonald. The sequestration of $10 million appropriated in FY 1986 funds for AIDS has not affected our ability to move ahead with AIDS research and prevention activities. At NIH the sequestration will not make it necessary to reduce at NIH the number of AIDS research awards, but only the amount of the grants. Other PHS agencies expect to meet their goals through careful review of individual awards and possibly some redirection in the scope of AIDS project contracts and cooperative agreements.

If Congress does not approve the rescissions, PHS would use the funds to expand ongoing AIDS activities in 1986. All of these funds would be obligated before September 30, 1986.

AIDS - RESCISSION DETERMINATION

Mr. Roybal. In what precise manner were proposed 1986 rescissions determined? Who or which agencies decided which AIDS-related line items to cut? Did the impetus for them come from OMB or PHS initially?

Dr. Macdonald. The Administration decided to propose for rescission all Congressional increases beyond the requirements that PHS had identified as a result of its reassessment of AIDS resource requirements dated September 1985. The rescission proposal reflects the agreement between the Department and OMB on ways to more precisely control the level of overall expenditures. As part of the Department, the PHS did not initially recommend a rescission of these funds.

Mr. Roybal. Recent research breakthroughs suggest that an "AIDS vaccine" may be feasible in 3-5 years rather than the 10-year time-frame previously projected. [Reference: research being carried out by Dr. Haseltine and Groopman et al in Boston]. Doesn't it make sense, then, to focus more 1987 funding on vaccine research? How much more funding?

Dr. Macdonald. We believe the request includes sufficient funds to continue our accelerated vaccine development efforts. PHS plans to spend $10.2 million in FY 1987 for vaccine development, compared to $14.8 million in FY 1986 and $10.2 million in FY 1985 for vaccine development.

HEALTH CARE AND CARE DELIVERY SYSTEMS

Mr. Roybal. Medicaid is currently reimbursing States at a rate of about $100 million annually in AIDS-related costs, most of them incurred in expensive in-patient hospital settings. That cost will inevitably grow, but it could be reduced drastically if all States were permitted to use Medicaid to pay for costs incurred in far less expensive home-care, hospice and other such settings. This out-patient model would be studied in four 1986 demonstration projects that the Administration now proposes to rescind. What is the wisdom of cutting relatively cheap programs whose results could save the government hundreds of millions of dollars over the next several years? Doesn't the government in fact have a responsibility to encourage the reduction of costs, and a role in facilitating that reduction?

Dr. Macdonald. Through the Health Care Financing Administration and the National Center for Health Services Research, the Department spends a large amount of money (approximately $38 million in total requested for 1987) on general research in health services and health care cost containment, including research on alternatives to more expensive inpatient care, such as hospices, home health, and adult out-patient services, which have applications to AIDS care and treatments and epidemiological studies, research on therapeutic treatments and vaccines, and preventive education programs for AIDS. If these efforts are successful, they could significantly affect the cost of AIDS care.

Mr. Roybal. Once designated as disabled for Social Security Disability Insurance purposes, people with AIDS must spend-down their personal resources and wait two years before becoming eligible for Medicare benefits. Yet most people with AIDS are not alive two years after their initial diagnosis. For catastrophic illnesses such as AIDS, wouldn't it make sense to waive the two-year waiting period?

Dr. Macdonald. We do not believe it is appropriate to waive the two-year waiting period for Medicare disability eligibility for catastrophic illnesses, such as AIDS. SSA's policy for determining eligibility for disability benefits for individuals with AIDS is the same as for all other impairments. This waiting period is designed to ensure that Medicare disability payments are provided only for long-term care, rather than acute illnesses, and to ensure that Medicare provides reimbursement only after all other sources for financial medical assistance are first exhausted. This policy applies in all cases, even for other catastrophic illnesses such as cancer.

AIDS
PUBLIC AND PRIVATE SECTOR PROGRAMS AND INITIATIVES

Mr. Roybal. What private sector initiatives have been undertaken in the areas of AIDS public education and prevention and how, if at all, are they coordinated with government efforts?

Dr. Macdonald. The Public Health Service has worked very closely with various segments of the private sector with respect to AIDS information and education need. Below are two examples that will illustrate the kinds of activities.

1. During the last six months the American Red Cross (ARC) began an AIDS national public education campaign. PHS scientists provided technical oversight to this campaign which provided useful materials to the public.

Currently, two television public service announcements (PSAs) are being mailed out to stations around the country. These PSAs, prepared jointly by ARC and PHS, feature a message aimed at dispelling rumors about AIDS. Both encourage viewers to phone the PHS AIDS toll-free hotline for the Facts about AIDS. The ARC did the production of the spots, while PHS provided the ancillary materials and performed pre-release focus group testing to ensure understandability and understanding of the messages. Radio spots and posters were also produced in the same fashion.

Plans are now under way for the production of another wave of television and radio PSAs. These will feature messages on the dangers of casual sex and IV drug use as it relates to AIDS.

2. Under contract, PHS is sponsoring the development of a plan and charter for a national coordination coalition on AIDS information and education. This activity is based on the recommendations of a group assembled by PHS to discuss AIDS information and education. The coordination group will include representatives of various public and private section groups with an interest in and responsibility for education of various segments of the public with respect to AIDS. The group will attempt to assure that there are no gaps in educational efforts, and that there is not overemphasis on one approach, at the expense of another. It is planned that PHS will handle the management of the coordination function.

Mr. Roybal. Does PHS believe that private sector programs, in effect, offset its own programs -- that is, that a $17 million private initiative permits PHS to reduce its commitment by a similar amount; or does PHS intend to encourage private efforts by augmenting them with its own funds?

Dr. Macdonald. PHS believes that public and private sector initiatives to educate various segments of the public are extremely necessary to effect the prevention and control of AIDS. PHS in many cases has provided seed monies to help private organizations begin their initiatives. For example, PHS is providing support to the American Medical Association to begin its AIDS education efforts.

As mentioned in the response to the previous question, the work of the national coordinating council on AIDS will be directed at helping private and public sector groups to fill all the gaps in AIDS information efforts and to avoid any duplication of expensive programs.

Thus, PHS regards the coordination of public and private sector efforts as essential in educating the public about AIDS. Neither PHS nor private sector groups is solely responsible for meeting these needs, but the best efforts of both groups will be required. PHS will continue its efforts in conjunction with the private sector.

AIDS TECHNICAL ASSISTANCE

Mr. Roybal. To support capacity-building grants, what does PHS propose to provide states and localities in the way of technology transfer of materials and expertise?

Dr. Macdonald. CDC will use three methods of providing technology transfer and expertise to support capacity-building cooperative agreement recipient areas. First, CDC staff will be providing on-site technical assistance. Based on experience in providing technical assistance for other grant programs, CDC expects this process related to AIDS programs will include a close review of proposed procedures, identify common operational problems, and facilitate an exchange of ideas about workable approaches and techniques. CDC will document these problems and viable solutions and make this information available to all States through periodic communiques and follow-up technical assistance visits. Second, CDC will carefully review program narrative reports from cooperative agreement areas and disseminate ideas and technology that would be useful for all to consider. Third, among the key responsibilities of the several Community-Based Demonstration Projects for AIDS Prevention and Risk Reduction is the need to test new approaches and throughly document all activities. These areas will then participate with CDC staff in efforts, such as training, to assure all other AIDS health education/risk reduction programs are able to rapidly implement the best available technology with a minimum of wasted effort.

Mr. Roybal. Is this technical assistance to be paid for out of the grants budget or other sources?

Dr. Macdonald. The technical assistance will be supported from CDC program operations funds for AIDS.

Mr. Roybal. What is the total estimated cost of technical assistance?

Dr. Macdonald. The total estimated cost of supporting and performing technical assistance to be provided by CDC is approximately $1 million.

AIDS INFORMATION CLEARINGHOUSE

Mr. Roybal. Do we need a central "AIDS Information Clearinghouse" on the order of those already in existence for cancer and other diseases, to coordinate and distribute AIDS education and prevention expertise?

Dr. Macdonald. We do not believe a formal "clearinghouse" is necessary. All of the PHS agencies responsible for AIDS activities are getting the most up-to-date information out to the research community and the public as quickly as possible. Specific current efforts we are using to assist in spreading AIDS information include the current AIDS hotline at CDC, OASH-coordinated public information campaigns, CDC's $20 million worth of grants for AIDS health education/risk reduction/prevention projects, as well as the ongoing ability of all involved PHS agencies to respond to specific questions about AIDS education and prevention.

Mr. Roybal. How much would such a clearinghouse cost?

Dr. Macdonald. It is estimated that the administrative apparatus for an AIDS information clearinghouse would cost an additional $3 million if it were modeled after other clearinghouses already in existence.

Mr. Roybal. Who would operate it?

Dr. Macdonald. Such a clearinghouse would be more appropriately managed through a cooperative agreement or contract with a qualified outside vendor.

OFFICE OF MINORITY HEALTH

Mr. Roybal. Former Secretary Heckler established the Office of Minority Health. Could you please provide for the Committee a list of your plans to spend the $3 million in the account?

Dr. Macdonald. When the former Secretary announced the establishment of the Office of Minority Health, the figure of $3 million was used as a proposed budget. In view of the fact that part of the fiscal year had gone by, $2 million was made available for Fiscal Year 1986. If this amount is not sufficient, additional resources will be made available. The funds will be used for:

--Salaries and other administrative expenses
--Support of State and local conferences
--Anticipated contracts relative to risk factor reduction programs in minority areas.

Contract efforts will focus on:
-- Development of culturally sensitive and culturally appropriate health promotion/disease prevention messages and information utilizing a variety of media such as music videos, posters, billboards, movies, and public service announcements. This will be coordinated with a national strategy to get opinion leaders and national figures to incorporate risk factor reduction messages into their daily work and art.

-- Development of community coalitions to promote the concept of multi-party partnerships among various community-based institutions which will organize to promote better health. For example, an alliance between the churches, the school system, the police department, and the health department.

As the Office continues to further develop and refine its long-range and near-term objectives of improving the health of minorities, it will be planning and organizing specific activities to meet these objectives, and related supporting budget plans for Fiscal Year 1987 bill be finalized.

DIABETES IN MINORITIES

Mr. Roybal. In the Task Force Report on Minority Health completed by the Department of Health and Human Services, diabetes was included as one of the most important contributors to excess mortality in minorities. Are you planning any efforts to deal with the serious problem of diabetes in the Hispanic population? What are these efforts?

Dr. Macdonald. Some portion of the diabetes problem in Hispanics may be genetic. The most important modifiable contributor to diabetes in most populations in general and in the Hispanic population in particular is the prevalence of obesity. The Office of Minority Health is planning to implement two projects aimed at risk reduction factors, of which obesity is one. One project is the development of health promotion/disease prevention public education materials targeted toward the minority populations. This will be part of a national effort to get opinion leaders and national figures to focus on messages on reducing risk factors of all kinds, including obesity.

The second project to be implemented will foster health promotion efforts in all areas at the community level by forming multi-party partnerships among various community-based institutions, such as schools, health and police departments, to reduce the risks associated with unhealthful lifestyles and habits.

Mr. Roybal. Is there a need to do an educational effort in the area of diabetes to push for early diagnosis and the importance of maintaining treatment? How much do you estimate this effort will cost?

Dr. Macdonald. Education is essential to the control and treatment of diabetes. We are planning two contract efforts geared toward education and behavioral modification covering a variety of minority health issues. In the vast majority of adult onset diabetes cases, the key to effective treatment is weight loss. This is an area of behavior which can be modified through educational efforts. The total cost of these efforts will be approximately $2.2 million and will encompass the diabetes issue.

OFFICE OF MINORITY HEALTH STAFFING

Mr. Roybal. Please provide for the Committee a listing of the staff positions of the Office of Minority Health detailing the responsibilities, salary, and racial or ethnic background of each of the persons in these positions.

Dr. Macdonald. The Office of Minority Health is a new office still in the process of establishing its goals and responsibilities. The Office will eventually be staffed with 11 employees; however, only the Director's position is currently filled with a permanent employee. It is anticipated that when fully staffed, the Office will be composed of the following positions:

Position	Approximate Salary per position
Physicians (3)	$65,000
Senior public health analysts (2)	45,000
Program analysts (3)	24,000
Support staff (3)	15,000

The Director is currently seeking to recruit additional full-time staff to the Office. The missions statement for the Office of Minority Health contains nine components which address six specific diseases and four minorities. The staff selected will be chosen for their abilities to contribute solutions to minority health problem areas.

AIDS: DOD COLLABORATION

Mr. Early. Doctor, for FY 86, a total of $95.1 million was appropriated to the Department of Defense for AIDS activities. $55.1 million is for testing for all services. $40 million was also provided to the Army for research with directive that the Army's research activities be coordinated with NIH and other agencies engaged in AIDS research. What is the rationale for excluding these research funds?

Dr. Macdonald. The consolidated AIDS account in OASH has been developed using only the funding under the control of the Labor-HHS Appropriations Subcommittee. The purpose of establishing this account is to provide the Assistant Secretary for Health more direct control over a significant amount of funds used to combat this disease and to provide a focus of greater coordination and cooperation in the Public Health Service. Because it is important that this account be established as soon as possible, only funds under the control of the single subcommittee were considered.

As Dr. Fauci, of the National Institute of Allergy and Infectious Disease, testified , NIH is servicing in an advisory capacity to the Department of Defense (DOD). NIH has been collaborating with DOD components on various aspects of AIDS research, and has been coordinating our AIDS efforts. This collaboration and coordination of our AIDS efforts will enable us to avoid possible overlapping of research efforts and to make the best use of AIDS resources. The following are brief descriptions of our collaborative efforts.

o National Cancer Institute:

- Starting with some of the earliest studies in Dr. Callo's laboratory on isolation of HTLV-III from AIDS and ARC patients, the Army (specifically Dr. Robert Redfield) collaborated and provided essential fresh blood and tissue samples.

- The Army has collaborated with the molecular biology group under Dr. Flossie Wong-Staal to demonstrate the genomic diversity of HTLV-III.

- The method of transmission of HTLV-III has been a collaborative project showing that heterosexual transmission does occur, that spouses of AIDS patients are at risk, and that prostitutes can transmit HTLV-III.

- Currently, studies are ongoing into the pathogenesis of Kaposi's sarcoma. The Army has extensive clinical resources and appreciates the need of very fresh tissue and blood specimens for virological studies. The Army has access to patients on a worldwide basis and the opportunity for epidemiology on an unprecendented scale. Combined laboratory-based studies including serology and attempts to isolate variants should prove useful to trace the origin of HTLV-III and perhaps initiate studies of other related viruses. A new collaboration has been started with Dr. Zagury at the University of Paris for AIDS vaccine studies.

o National Institute of Allergy and Infectious Diseases:
  - Collaboration between NIAID and Walter Reed Army Institute for Reserach (WRAIR) on evaluation of antivirals for AIDS has been established by the extramural staff of the AIDS Program.
  - WRAIR ad-hoc representation on the AIDS Drug Selection Committee has been established.
  - The staff of the NIAID AIDS Program is currently negotiating with USAMRIID, DOD, to initiate an antiviral screening program.
  - Members of the NIAID staff and the DOD have been in communication with regard to collaborative efforts that may be possible in the area of vaccine development.
  - Members of NIAID staff have developed communication channels with members of WRAIR for future discussion and coordination of additional research activities and antiviral drug development.

o National Institute of Dental Research:
  - Investigations regarding the natural history of oral conditions and diseases in AIDS patients are being planned between NIDR and Walter Reed.
  - Preliminary plans have been initiated by NIDR with the VA to monitor the oral health status and treatment needs of AIDS patients.

Mr. Early. Was consideration given to bringing these research funds under this new account? If not, why not?

Dr. Macdonald. The discussions to establish the consolidated account were carried out within the Office of Management and Budget, and I do not know if consideration was given to including the Army research funds for AIDS.

ACQUIRED IMMUNE DEFICIENCY SYNDROME

Mr. Early. Under this proposal, who makes the decision on what to fund and how much money will be allocated to the agencies engaged in AIDS activities? Who has the final word? Will these decisions be made before a budget request is submitted to Congress?

Dr. Macdonald. Our proposal to consolidate the AIDS resources into a single appropriation will not change the way in which budget estimates are developed and ultimately how the resources would be allocated. The AIDS budget would be formulated based upon research and prevention priorities and would continue to originate at the individual agencies. The agencies' requests will be reviewed by the PHS AIDS Executive Task Force, Office of the Assistant Secretary for Health, and submitted to the Office of the Secretary, the Office of Management and Budget (OMB), the President, and Congress as a single appropriation. As is the current procedure, OMB and the President would have the final word on our Congressional budget request. Planned Agency allocations of AIDS resources would be presented as a part of our budget submission to Congress.

Mr. Early. Doctor, wouldn't this create another layer of bureaucracy to go through before funds could actually be put to use?

Dr. Macdonald. No. The budget for these activities are currently reviewed and approved in the same manner. We are not creating an additional layer, but are simply adding a full-time PHS AIDS Coordinator to assist the Assistant Secretary for Health and the existing PHS AIDS Executive Task Force. Dr. Walter Dowdle has been appointed as the PHS AIDS Coordinator and will be devoting his full time and attention to the overall coordination of PHS AIDS activities. While some minor additional financial management paperwork will be created, we regard the benefits from better overall coordination and flexibility to be worth this.

Mr. Early. Given all the planning and coordination that we've been told is going on, and how effective it is, why add more bureaucracy?

Dr. Macdonald. May I say that the coordination of the PHS AIDS efforts continues to be outstanding.

We are not creating an additional bureaucratic layer, but simply adding a full-time AIDS coordinator (and support staff). In my capacity as Acting Assistant Secretary of Health, I found that our AIDS effort was demanding more and more of my time and effort and leaving less time to oversee the total mission of the Public Health Service. The PHS AIDS Coordinator will chair the PHS AIDS Executive Task Force and will be responsible for planning, formulating, coordinating and monitoring the AIDS control effort; and would manage a process whereby PHS could assure itself that the most important research and prevention priorities are supported.

ALLOCATION OF AIDS FUNDS

Mr. Early. Doctor, how will the $203 million which you are requesting be allocated among the agencies involved?

Dr. Macdonald. Operations responsibility for AIDS activities will continue to reside in the individual agencies involved. We are curretly planning to allocate the resources to these agencies request (i.e., $45,409,000 for CDC, $142,990,000 for NIH, $13,733,000 for ADAMHA, and $1,350,000 for CASH). However, final FY 1987 allocations to the individual agencies will be based on their AIDS operational plan approved at that time through the PHS AIDS Executive Task Force, and will be allocated through reimbursable agreements.

Mr. Early. What portion of the request is related to intramual activities and what is the associated FTE level?

Dr. Macdonald. The FY 1987 request includes approximately $44.1 million and 403 FTEs for intramural activities. This includes $31.5 million and 235 FTEs for NIH; $12 million and 168 FTEs for CDC; and $0.6 million for ADAMHA.

Mr. Early. Doctor, won't this make intramural program planning at CDC, NIH and ADAMHA more difficult -- add an element of uncertainty?

Dr. Macdonald. We do not believe that the establishment of a central focus for AIDS at the Assistant Secretary for Health level will adversely affect intramural planning; nor do we believe that centralization would create an element of uncertainty.

The total PHS request for AIDS represents the sum of the AIDS requirements identified by the individual agencies and is consistent with the priorities identified in the 1987 budget request and with the PHS Plan for Prevention and Control of AIDS.

Mr. Early. It would seem to me that this process is going to add an element of uncertainty to the research endeavor -- that agencies won't move forward with projects until they have the funds in hand.

Dr. Macdonald. Again I will say that I do not believe that consolidation of the AIDS activity will create an element of uncertainty.

The proposal contained in the consolidated AIDS account represents our highest AIDS research and prevention priorities. The priorities were identified by the individual agencies and their request was formulated based on those priorities. The PHS agencies deal with uncertainty every year but planning continues. Since AIDS is such a high priority, the support for it has been strong. Funding for AIDS has consistently increased. Agencies should be able to plan with little uncertainty.

AIDS COORDINATOR

Mr. Early. Doctor, what kind of decision-making authority will the AIDS coordinator have, the justification isn't very specific on this point. In what area?

Dr. Macdonald. The AIDS coordinator does not have any decision-making authority. The coordinator chairs the AIDS Executive Task Force and in this capacity is responsible for presenting the Task Force recommendations to the Assistant Secretary for Health. His duties also include providing the day-to-day coordination of the PHS AIDS effort.

Mr. Early. Who is the current AIDS coordinator? And, will this individual be the permanent coordinator?

Dr. Macdonald. Dr. Walter Dowdle of CDC will be the acting coordinator, until such time that a permanent AIDS coordinator is named.

AGENCY BUDGET/APPEAL PROCESSES

Mr. Early. Doctor, what kind of an appeal process will there be for the agencies (CDC, NIH, etc.)? Will there be a process whereby an agency can appeal a decision of the coordinator -- for example on a "hotly contested" matter where opinion is pretty evenly divided.

Dr. Macdonald. The AIDS Executive Task Force is charged with coordinating the PHS efforts to solve the public health research and clinical problems associated with AIDS. In this role, the Task Force is responsible for reviewing agency request for AIDS resources and making recommendations as to the appropriate level of funding necessary to effectively carry on AIDS research and prevention activities.

The Task Force is comprised of representatives of all the agencies involved with AIDS activities and any recommendations of this group represent the initial resolution of any "hotly contested" matters. The AIDS coordinator makes no independent decisions, but as Chairman of the Task Force, reports its recommendations to the Assistant Secretary for Health for a final decision. Individual agencies can always appeal (Task Force decisions) directly to the Assistant Secretary of Health.

Mr. Early. What kind of appeal process has been established for the development of a budget request -- for example, where an agency feels strongly about the need for additional resources?

Dr. Macdonald. If any agency identifies an additional need for AIDS resources, the Agency submits its request for these additional resources to the Assistant Secretary for Health. The Assistant Secretary for Health would request that the AIDS Executive Task Force review the scientific merit of proposals, decide the priority of proposals, determine whether the proposal warrants a request for additional resources, and ultimately makes a recommendation to the Assistant Secretary for Health. Any agency appeal would be made directly to the Assistant Secretary for Health.

Mr. Early. Doctor, would you describe, in some detail, how budget requests for AIDS funding would be developed under this proposal?

Dr. Macdonald. The PHS budget and appeal process, under the proposed system, will not change from the system currently being used. Institutes and bureaus within the PHS will submit their budget requests to the agency heads; the agencies will submit their requests to the Assistant Secretary for Health; PHS submits it's request to the Department; and the Department submits it's request to OMB. Appeals can be made at each of these steps of the process.

The budget request for AIDS resources is somewhat unique in that (1) the AIDS Executive Task Force reviews the most current Plan for Prevention and Control of AIDS and revises according to accomplishments, current information; 2) the Assistant Secretary for Health (ASH) requests agencies to submit budget proposals based on the Plan and assigned responsibilities; and 3) the Task Force (representatives from each agency are members of the Task Force) reviews and discusses the agencies' AIDS request and makes recommendations to the ASH. The ASH has the final say in the level of AIDS funding that will be requested in the OASH submission to the Department.

Any AIDS appeals at the Departmental and OMB levels will be a consolidated appeal; individual agency concerns/appeals would be incorporated into the consolidated account. This affords PHS the opportunity to present the total PHS AIDS effort rather than fragmented (individual agencies) presentations.

AIDS RESEARCH COORDINATION

Mr. Early. How much are you currently spending on AIDS research coordination?

Dr. Macdonald. Currently, we do not identify any direct costs associated with AIDS coordination. However, indirectly we are spending money on AIDS coordination which would include coordinating research and all AIDS activities (e.g. Dr. Dowdle's salary).

Mr. Early. Doctor, you currently have an AIDS coordinator, is that correct? What is the present salary of the coordinator?

Dr. Macdonald. Yes, Dr. Dowdle of the Centers for Disease Control is the PHS AIDS coordinator. The direct salary totals $68,700 (SES-5).

AIDS TRAVEL FUNDS

Mr. Early. Doctor, you are requesting $10,000 for travel associated with this activity. Why do you need these funds?

Dr. Macdonald. These funds are necessary to: 1) maintain close coordination and communication with State and local health departments; 2) consult with professional organizations involved in the AIDS effort; 3) attend scientific conferences and participate with advisory groups at international, national, State and local levels; and 4) participate in site reviews of various programs and activities.

ADOLESCENT FAMILY LIFE PROGRAM

Mr. Dwyer. Earlier this year, your office announced the availability of demonstration grants under the Adolescent Family Life Program, but states which already have more than one program are ineligible for the grants. New Jersey, which has only two AFL programs, as well as several other densely populated states, are excluded from applying. What is the rationale for excluding states on this basis?

Dr. Macdonald. The purpose of the Adolescent Family Life (AFL) program is to develop successful demonstration models that can be replicated in a variety of different settings and localities. In terms of resources, the AFL is a small program and cannot serve all of the adolescents in need. As a demonstration effort however, it can focus attention on the problem and provide support for the development of new approaches to dealing with it. Because the program is small and the need for replicable models in many different settings so urgent, geographic dispersion of the projects funded is very important.

Twenty-eight States and territories currently have either one or no projects which obviously indicates that there are large areas in the U.S. where communities do not have the benefit of an AFL model demonstration program available to them. The decision to limit this year's eligibility for funding to these States and territories, will afford them the opportunity to develop the types of model programs best suited to serve their populations needs.

That is not to say, however, that we fail to recognize the major problems that exist in densely populated urban areas, because the majority of our projects are already in these areas. The problem of teen pregnancy is not just an urban concern, however; it also exists as a major problem in other less populated, less urban areas. To ensure that projects are placed in areas where there is need (be they urban, suburban or rural), eligibility requirements for a grant award stipulate that each potential grantee must identify the incidence of adolescent pregnancy and related problems in the area proposed to be served, describe the economic conditions and income levels in that area, the existing services and the major unmet needs.

Mr. Dwyer. Ms. Gasper, earlier in our hearings, Labor Secretary Brock stressed the importance of providing dislocated worker funds on a discretionary basis so that they can be targeted to those areas of the country with the greatest need. Given the high rate of pregnancy among low-income teenagers in certain urban areas of the country, shouldn't we be targeting the limited funds available for AFL programs to those areas where the need is greatest?

Mrs. Gasper. We share your belief that funds should be targeted to areas of greatest need. Teen pregnancy is indeed a problem in major urban areas, but teen pregnancy rates are extremely high in some States with large rural populations and comparatively small urban populations. The majority of our projects are located in large metropolitan areas across the U.S. A great many others are situated in regional population centers. While we certainly want to target services to where they are needed most, Title XX specifically requires that, in addition to urban needs, we give special attention to the needs of rural areas. Section 2005(b)(2) states:

> In making grants for demonstration projects for services under this title, the Secretary shall consider the special needs of rural areas and, to the maximum extent practicable, shall distribute funds taking into consideration the relative number of adolescents in such areas in need of such services.

Mr. Dwyer. When do you foresee another grant announcement that will be open to all states with meritorious applications?

Dr. Macdonald. We are anticipating that 42 grantees will complete their project periods with FY 1986 funding. The 1987 budget request would fund an estimated 36 new demonstration projects. At this time we are considering the possibility of opening eligibility for FY 1987 grants to all States and territories.

USER LIAISON PROGRAM STAFFING

Mr. Hoyer. Dr. Marshall, can you assure me today that no permanent reassignments of user liaison program staff have been made or are in the process of being approved by the Assistant Secretary's personnel office?

Dr. Marshall. Mr. Hoyer, I cannot assure you that no permanent reassignments of User Liaison Program staff have been made. Staff in NCHSR are assigned to meet workload requirements of the operating programs. In my judgment, the current staffing of the User Liaison Program is appropriate for the existing workload. Should that workload change, staffing will be adjusted to match.

Mr. Hoyer. Can you assure me that no such permanent reassignments will be approved until this Subcommittee has an opportunity to reach a decision on the funding of this program?

Dr. Marshall. Reassignments have been made to match workload requirements within NCHSR. We will staff the User Liaison Program consistent with responsibilities assigned to it and would be pleased to receive any advice which the subcommittee may wish to provide.

Mr. Hoyer. Can you assure me that none of the eight established program positions will be abolished until this Subcommittee has acted?

Dr. Marshall. No program positions have been abolished and we do not intend to abolish positions. Vacant positions may be created as a result of reassignments to other vacancies within the Center. However we have no plans to change the table of organization of NCHSR.

COSTS OF WORKSHOPS AND SEMINARS

Mr. Hoyer. Dr. Marshall, it has been suggested that one of the reasons for the recent action related to the elimination of the contract activities of the program is their high costs. I believe that you stated that one workshop or seminar cost $197,000.

Please provide me with a list of the twenty most recent workshops and seminars and their costs.

Dr. Marshall. I indicated that the most recent 5 and 1/2 day workshop cost $153,000. For 26 participants, this was an average cost of over $6,200. I know that you have a list which shows much lower costs for other workshops sponsored under the User Liaison Program. I believe that list could only have originated from the User Liaison Program office. But because the Program Director is on extended sick leave, as is his assistant, and I have not seen a copy of the list, I cannot address its validity. NCHSR records show the following as the 20 most recent meetings. Not all of these are workshops. Some are seminars or briefing sessions. All have been carried out under contract and the contractors are identified. The cost for seminars reflects mostly the consultant fees and travel for one or two individuals hired by contractors to make presentations.

Clearly, many seminars have been conducted which involve one consultant speaking to a small group at a meeting in a State capital. Obviously these are much less expensive. It may well be appropriate to continue this type of activity.

My proposal for restructuring the User Liaison Program has been represented to State Legislators as a total elimination of all User Liaison activities. That is not what I am proposing. I am proposing only eliminating those activities which are excessively expensive. I am attempting to assess alternative strategies. I want to emphasize before this Committee that I am not opposed to the User Liaison Program in principle. I supported its being specifically addressed and included in our authorization under P.L. 98-551, including a set-aside to guarantee a funding base for dissemination activities including the User Liaison Program. What I am trying to do is to stimulate evolution of the User Liaison Program consistent with current patterns of needs and resources available for health services research and its dissemination.

LEWIN AND ASSOCIATES, INC.

Seminar on the Supply and Distribution of Physician Manpower
Cost - $3,821
State - Texas

Seminar on the Supply and Distribution of Physician Manpower
Cost - $7,172
State - Participants from several western states

Seminar on the Viability of Rural Hospitals
Cost - $2,165
State - Texas

Briefing for State and Local Officials on the Hospital Cost and Utilization Project
Cost - $4,166
State - Participants from several states

Seminar on Designing Application of Utilization Controls
Cost - $6,511
State - Participants from several states

Seminar on Uncompensated Health Care
Cost - $7,762
State - West Virginia

Workshop on Cost Shifting, Indigent Care, Financial Distress, and CON
Cost - $17,309
State- Illinois

Seminar on Uncompensated Care
Cost - $7,500
State - New Jersey

Seminar on the Supply and Distribution of Physician Manpower
Cost - $9,000
State - South Carolina

Seminar on the Supply and Distribution of Physician Manpower
Cost - $16,800
State - Participants from several states

ALPHA CENTER FOR HEALTH PLANNING

Workshop on Health Care Cost Containment
Cost - $62,100
State - Participants from several states (held in July, 1985)

Workshop on Health Care Cost Containment
Cost - $62,100
State - Participants from several states(held in August, 1985)

Workshop on the Role of Alcohol Treatment Services in Containing Health Care Costs
Cost - $37,913
State - Participants from several states

Seminar on Capital Investment in Health Care
Cost - $5,100
State - New Jersey

APPLIED MANAGEMENT SCIENCES, INC.

Seminar on Long Term Care Services for the Elderly
Cost - $10,969
State - Participants from several southern states

Conference on Innovative Approaches in Long Term Care
Cost - $15,959
State - Vermont

Workshop on Long Term Care for the Elderly
Cost - $51,107
State - Participants from several states

Workshop on Health Promotion and Disease Prevention
Cost - $61,107
State - Participants from several states

MOSHMAN ASSOCIATES, INC.

Seminar on Case Mix Nursing Home Reimbursement
Cost - $2,647
State - New Jersey

Seminar on Health Services Research Projects Conducted by the
Heller Graduate School, Brandeis University
Cost - $2,515
State - Participants from several New England states

NCHSR SUPPORT OF USER LIAISON PROGRAM

Mr. Hoyer. Dr. Marshall, last year in answer to a question posed by Congressman Early about the user liaison program you said and I quote, "...if I were to judge the success by the number of people who participated in it, and who send us letters saying that they have really gotten useful information, one would have to say it is a stunning success." What has happened to change your mind?

Dr. Marshall. The context of my exchange with Congressman Early was that while I received enthusiastic letters of appreciation from Legislators attending workshops, I was lacking in hard evidence with respect to whether it really made a difference in terms of their behavior or in terms of changes in the State sponsored programs. While I have found some evidence of User Liaison Program effectiveness, the impact does not justify the level and character of expenditures that were being made.

FEASIBILITY OF HEALTH SERVICES RESEARCH CENTERS AS A SUBSTITUTE FOR THE USER LIAISON PROGRAM

Mr. Hoyer. Dr. Marshall, you have gone on record in a letter to a member of Senator Leahy's staff that "the type of research information and technical assistance which has been provided by the User Liaison Program is available to state officials in a more cost effective way" from health services research centers located around the country.

It is my understanding that the principal activities carried out by the User Liaison Program are as follows:

- workshops and seminars on specific health and human services issues, signed exclusively for state and local government officials,
- skill oriented workshops
- synthesis of research findings which are designed exclusively to address the policy issues and problems of senior state and local officials.
- direct technical assistance to individual officials, legislative committees, executive agencies, as well as special commissions

(a) Was a comparative study of the type described above conducted? If so, by whom was it conducted and when was it completed?

(b) Were User Liaison Program staff notified of the study and, if so, did they provide information to the person or organization conducting the study? If so, what type of information was provided?

(c) Please submit to the Subcommittee a copy of the results of this study.

Dr. Marshall. Let me first provide context for the statement from the letter to Senator Leahey's staff which you quote.

> "There are now health services research centers in 28 States. The type of research information and technical assistance which has been provided by the User Liaison Program is available to State officials in a more cost effective way from those centers. To be sure, the match with local or in-State resources may not occur spontaneously without some assistance. We are prepared to continue to provide brokering between State or local officials and health services research experts. What we will no longer be able to afford is to subsidize travel and support meetings and workshops for which NCHSR provides funding. That decision is dictated by the need to maintain our research activities in the face of adverse budget actions. If we don't continue to develop an information base which derives from empirical research, there won't be any dissemination activity."

My statement with respect to cost-effectiveness was not based on a formal study. It was based on my own observations and experience. I have had multiple discussions with User Liaison Program staff over the past three years with respect to this program. The staff has been well aware of my concerns. These started when I arrived and found that they had been using a single contractor, with no competition in reselection, for a six-year period. They have been aware of my concern that the User Liaison Program was perceived by the State and local community as a program operated by that program and its contractors and not supported by the National Center for Health Services Research. They are aware of my concerns about the way in which programs were structured and the excessive control that was exercised by the program staff, and the amount of time that went into agenda building. I never took the position that these approaches were wrong, but I did question them and I did ask the User Liaison Program staff to consider making changes in the program in order to make the money go further.

As the Program Manager, I made the judgment with respect to the balance, in the context of resources available to the Center, between overall mission responsibilities.

LETTERS OF SUPPORT FOR USER LIAISON PROGRAM

Mr. Hoyer. A number of distinguished researchers recently sent a letter supporting continuation of the User Liaison Program to members of this Appropriations Subcommittee.

Since all of these researchers are Directors, Co-Directors or Chairs of some type of organization, such as a research center or academic department, I assume that they represent the type of researchers and research organizations you assert are "available" to provide "research information and technical assistance" to state officials in lieu of an active User Liaison Program as just described.

Yet the letter sent to the Subcommittee members by these individuals makes several relevant points, including:

- "As researchers, we believe the activities of the User Liaison Program assist policy makers to understand and apply the knowledge gained through research is a legitimate and vital function for the Federal government to carry out."

- "We know from our contacts with state and local officials at User Liaison Program workshops and elsewhere that this program has become a particularly important resource for state and local governments."

- "We urge you to support a restoration of funding for the User Liaison Program in both FY 1986 and FY 1987 so that state and local officials...may continue to benefit from our research efforts."

Why do you believe that these researchers, including directors of research centers and programs, oppose your view that an active, modestly funded User Liaison Program (i.e., $800,000 in contract funds annually), is not an effective way to convey research findings and related information to state and local officials?

Dr. Marshall. I have a copy of a letter, dated February 27, 1986, addressed to Chairman Natcher with a list of the individuals reported to have signed it.

In contrast, a more balanced view is contained in a letter on this issue addressed to Chairman Natcher from the President of the Association for Health Services Research. It is attached for the record.

Second, the February 27th letter does not correctly state the facts of the NCHSR proposal. It implies that no dissemination effort will be undertaken by NCHSR for FY 1986 or FY 1987. That is not accurate. As we have testified, we are proposing only to eliminate subsidies for travel by State and local officials to workshops conducted by consulting firms at Federal expense.

Mr. Hoyer. Prior to reaching your conclusion that research centers and other academic institutions can and will provide, in an effective manner, such information and assistance, did you communicate verbally or in writing with any of the state officials who have benefitted from User Liaison Program assistance to obtain and assess their own personal experience with such an approach? If so, please provide the Subcommittee with copies of any correspondence on this subject. If your communications were verbal in nature, provide the Subcommittee with a summary of the

THE UNIVERSITY OF NORTH CAROLINA
AT
CHAPEL HILL

[illegible]

[illegible]

March 14, 1986

The Honorable William H. Natcher
2333 Rayburn House Office Building
U.S. House of Representatives
Washington, DC 20515

Dear Congressman Natcher:

It has come to my attention that you and your colleagues on the House Subcommittee on Health and Human Services Appropriations have been advised in recent days about the decision of the National Center for Health Services Research/Health Care Technology Assessment (NCHSR/HCTA) of the U.S. Public Health Service to restructure its program in research information dissemination. I am writing to reassure you that many of us within this broad field (that is, the field of health services research) do not agree with the protest being raised by some that these changes spell the end of an effective and appropriate degree of attention to research information dissemination by the NCHSR/HCTA.

Clearly the dissemination of research-based information to those in a position to use it in effecting health policy decisions at the state and local levels is important; even the NCHSR/HCTA's director, Dr. John Marshall, has supported this view in his designation of this activity as one of the three major emphases of his agency. However, general support for basic and applied research on health services has been in a state of decline in recent years and it is of paramount importance that support for research itself receive highest priority at this time. Without at least a minimum level of support for research on the problems related to the provision of personal health care services, it makes no difference what support is given to information dissemination.

Furthermore, since the time when the "User Liaison Program" of the NCHSR/HCTA began, the number of university-based and free-standing research centers conducting health services research has increased substantially. At the present time there is at least one such center in almost every state. Many of these centers are fully capable of rendering expert technical assistance and advice to public and private agencies with need for research-based knowledge and experience when the need arises. Many of these centers have considered these activities an important part of their overall program and many, such as our Center here at the University of North Carolina, have been given state funds for this purpose. Our Center, and several others as well, have received private funds from several large health cre organizations for the purpose of conducting training and information disseminatio efforts throughout the United States for the benefit of public sector decision makers who have a need for understanding the latest and most effective techniques for making resource allocation

Congressman William H. Natcher
March 14, 1986
Page 2

decisions based on cost-effectiveness and cost-benefit criteria. In other words, the decision by the director of the National Center for Health Services Research to restructure the User Liaison Program, as part of an overall consideration of priorities of the National Center during this period of budget constraint, is seen by those of us who are most active as researchers and as sources of information and technical assistance by the research user community as part of what any other agency of Federal Government will be facing as the exigencies of the current situation arise.

As the current President of the Association for Health Services Research I have been very much aware of the efforts by you and the members of your Subcommittee in recent years to give this field of applied research the kind of support that will enable us to provide the nation with valuable information needed for planning and evaluating the expenditure of public funds for personal health care services for the American people. I hope you will let us know when we can be of assistance to you in this regard.

Yours sincerely,

Gordon H. DeFriese, Ph.D.
Professor of Social Medicine
and Director, Health Services
Research Center, University
of North Carolina at Chapel Hill

views so expressed to you, including the names and titles of the officials who provided such views.

Dr. Marshall. I was well aware, from the comments and mail that I have received over the past several years, that most of the people who continue to attend User Liaison functions feel that they gain personally from the experience. It provides them with an opportunity to travel, to meet other legislators who may have similar problems, and to be exposed to consultants who are familiar with the literature but who are unencumbered with the responsibility of dealing with legislative burdens or program operations in a state. While I did not consult with them specifically with respect to my plans for the User Liaison Program, I know operating officials and legislative officials in states who have found health services research centers in their states to be useful.

Mr. Boyer. If you did not contact such state and local officials, please provide your rationale for failing to do so.

Dr. Marshall. I did not contact State and local officials to ascertain their opinions with respect to the User Liaison Program. Those who are frequent participants in meetings are enthusiastic about it. Those who have not participated in it have little basis for making a judgment. As Director of the National Center, I am responsible for allocating resources to various components of the Center. I made the determination, based on my own judgment and experience, to protect the basic research activities of the Center from the effects of Gramm-Rudman-Hollings. Even before then, I had begun to doubt the wisdom of the level of expenditures that were being made by the User Liaison Program in the overall context of the balance between intramural research, extramural research and this particular aspect of our dissemination program.

ANALYSIS OF USER LIAISON PROGRAM EXPENDITURES

Mr. Boyer. In the above mentioned letter, as well as in other letters about the User Liaison Program which you have written to other Congressional offices, you consistently and repeatedly refer to your "analysis" of the User Liaison Program's contract expenditures. You appear to base much of your decision to terminate the Program's contractual activities, i.e., workshops, seminars, research syntheses, and technical assistance, upon this "analysis." It would also appear from your written statements that this "analysis" entailed merely breaking down contract expenditures according to various types of expenses. Is that correct?

If so, please provide the Subcommittee with the written and numerical results of this "analysis," as well as the date the analysis was requested and the date the results were provided to you. Also identify who conducted this "analysis."

Dr. Marshall. This analysis was completed in January but I am not certain of the date. It was provided to me on the same day as I requested it. A copy was provided to Mr. Fordham several days later. This occurred in January of 1986.

In reviewing the program expenditures, across the three contractors involved, I identified six categories of expenditures. These include labor costs, other direct costs, overhead, travel, general and administrative expenses paid to the contractor, and contractor fees. We further allocated these two components to include the substantive component which is defined as those expenses associated with the preparation of material for presentation, the other direct costs, travel and contractor overhead items for individuals making presentations. The second component includes those associated with administrative functions. The allocation is as follows:

Substantive

Labor = 40%
Other Direct Costs = 3%
Contractor Overhead = 13%
Travel = 11%
General Administration = 3%
Contractor Fees = 5%

Administration

Labor = 4%
Overhead = 5%
Travel = 11%
General Administration Paid to Contractor = 1%
Contractor Fees = 2%

Mr. Roper. In the letters referred to above, you also consistently and repeatedly cite a percentage of contract funds used for various purposes, a 40% figure which has been derived from your "analysis" of User Liaison Program contract expenditures. Your reference to this figure is always followed by a statement which refers to your view that "more cost effective mechanisms" should be developed or already exist.

One can only infer from these repeated statements that the "analysis" of the User Liaison Program's contract expenditures is, in your view, somehow related to the cost effectiveness of that Program. Do you feel that a cost breakout of the Program's contract expenditures constitutes a complete and valid measure of effectiveness or cost effectiveness? If not, exactly what does your "analysis of expenditures" purport to measure?

Dr. Marshall. My analysis measured only the relative utilization of funds by gross categories. My judgment is that the contractor overhead and fees are too high and that the travel, lodging and subsistence for legislators do not constitute an appropriate use of funds that are appropriated to support health services research or dissemination. I also reviewed some of the written material and the cost for its preparation. For example a synthesis of manpower issues was prepared at a cost to the program of $114,000 exclusive of the printing and mailing. That is a great deal of money to pay for summarizing research, the opinions of the contractor personnel who wrote it and a dollop of common sense. It may be handy and efficient to have this in a summary form, but it is not a good use of the NCHSR appropriation.

QUESTIONS OF THE RELATIVE EFFECTIVENESS OF THE USER LIAISON PROGRAM AS COMPARED TO OTHER NCHSR ACTIVITIES

Mr. Boyer. A recent letter to Mr. Patrick De Leon of Senator Inouye's staff, signed by Wilford Forbush, Deputy Assistant Secretary for Health Operations, Public Health Service, which I presume was prepared by your office, states:

> "Let me assure you that NCHSR intends to continue the User Liaison Program. However, it will not be continued in its present form. That is a decision driven not only by the need to absorb a reduction in funding during FY 1986, consistent with the Gramm Rudman Hollings Initiative, but has also been based on an assessment of the relevant effectiveness of that portion of NCHSR's activities relative to its research mission and other activities which have also been the object of special instructions by the several committees which oversee the Public Health Service." (emphasis added)

Please describe the "assessment of relative effectiveness" upon which you state that your decision was partially based. More specifically, please provide the Subcommittee with the following:

- a copy of the results of this "assessment of relative effectiveness"
- specification of the measure that were used to assess the effectiveness of the User Liaison Program's activities in terms of the benefits or outcomes derived from these activities
- specification of the measures that were used to assess the effectiveness of the "other NCHSR activities" referred to in the above mentioned letter
- if different measures were used to assess the effectiveness of the User Liaison Program as compared to the measures used to assess the effectiveness of NCHSR's "other activities," please explain how you reached any judgments concerning relative effectiveness
- when this "assessment of relative effectiveness" was conducted and completed, and who conducted this assessment?

Dr. Marshall. The assessment of relative effectiveness is my own. It is not written down. Section 305 of Public Health Service Act is explicit with respect to a number of activities which we are to address with the appropriated funds. My reading of the statute leads me to conclude that the bulk of our resources should go for the support of research. Without research, there is nothing to disseminate. In this authorizing section of the PHS Act running for several pages, the User Liaison Program is mentioned only as a sub-activity under our dissemination responsibilities. The Congress specified that a proportion (10% or $1.5 million) should be available for dissemination, technical assistance, and the User Liaison Program. My proposed action is consistent with that section of the statute. One million five hundred thousand dollars would support approximately 10 health services research grants.

MEDICAL MALPRACTICE

Mr. Boyer. A great deal has been written about the "crisis" in medical malpractice. I am not certain that the question of professional liability is a Federal issue per se, but, I wonder if there are some health policy implications that ought to be addressed. Do you have any thoughts on this, and would you tell us what, if anything, the National Center could be doing to help clear up some of the confusion?

Dr. MacDonald. We know that the current "crisis" in medical malpractice (and generally other forms of liability) primarily is one of rapidly rising premium cost. In contrast, the crisis of the mid-1970's was one of insurance availability. Newspaper and trade journals are filled with argument and counterargument by health care providers, lawyers, and the insurance industry. National policy action, however, requires some measure of empirical data together with the current abundance of anecdotal information. Not enough scientifically-based findings are available to carefully distinguish among the various arguments and options.

Some of the researchable issues that have not been adequately addressed include:

- Comparative analysis of recent state medical malpractice laws and tort law and other factors on the relative incidence of claims, the size of malpractice claims, and on the process and level of settlement.
- Analysis of the effects of the increase in medical malpractice premiums, claims, and settlements on the cost, delivery, and mix of medical services.
- Systems analysis of the insurance industry with emphasis on the understanding of secular trends in the economics of establishing medical malpractice premiums.
- Study of the relationship between trends in malpractice liability and negligent injury--how viable is the "deterrent effect?"
- Small-area analysis of the relationship between variations in medical practice, interventions to change standards of care, and the extent and nature of malpractice claims.

Mr. Boyer. Are there health services research questions that could be investigated which would help form national policy for dealing with the crisis in medical malpractice? How much will it cost to address them?

Dr. MacDonald. Areas of potential research in medical malpractice could include:

- Analysis of how new economic incentives (DRG payments to hospitals and greater use of capitation payments) affect the use of "defensive medicine."

- Evaluation of hospital efforts in quality assurance and risk management and their relationship to claims and awards.

- Small-area analysis of the relationship between variations in medical practice, intervention to change standards of care, and the extent and nature of malpractice claims.

- Analysis of the problems and possible solutions associated with extending malpractice insurance to non-physician health care providers.

- Comparative analysis of state medical malpractice laws, including multivariate analysis of the effect of changes in tort law and other factors on the relative incidence of claims, the size of malpractice claims, and on the process and level of settlement.

- Analysis of the effects of the increase in medical malpractice premiums, claims, and settlements on the cost, delivery, and use of medical services.

- To what extent does the DRG system of hospital finance and capitation payment help to "distinguish defensive medicine from the over-utilization that results from economic incentives inherent in fee-for-service medicine?"

PURCHASE OF NON-PROFIT HOSPITALS

Mr. [illegible]. On a regular basis, it seems, we keep hearing about community hospitals being purchased by major health care corporations. Usually, some one tries to make the case that hospitals which are owned by these corporations operate at a lower cost and more effectively. Has the National Center looked into this, and what have you learned?

Dr. Macdonald. NCHSR-supported research has tracked a number of fast-paced developments in our health care system. Some of these are multihospital systems, preferred provider organizations, for-profit HMOs, and freestanding emergency centers.

The work related to multihospital systems reveals that:

- System hospitals have higher costs, primarily due to higher mark-ups on ancillary services.

- There appears to be little difference between MHS and independent hospitals in terms of access to care and quality of care.

- The major advantage of system hospitals is their enhanced ability to operate in the capital markets.

Mr. Hoyer. Along the same lines, is there a trend toward investigator-controlled HMO's? How do they compare to nonprofit HMO's?

Dr. Macdonald. For-Profit HMOs:

- During the period 1982-1985, the number of new Federally qualified, for-profit HMOs rose 16 times more quickly than the number of new non-profit HMOs; in 1984, 7 of the 14 largest Federally-qualified HMOs were for-profit.
- The Independent Practice Association (IPA) model is the fastest growing segment of the HMO market.
- For-profit HMOs appear to be more costly than not-for-profit HMOs and have an increased ability to raise capital.

VARIATIONS IN MEDICAL CARE

Mr. Hoyer. We hear a great deal about large differences in the rates for certain surgical procedures between different geographic regions. Can something be done to control that?

Dr. Macdonald. Recent NCHSR sponsorship of Wennberg's research has shown that individual physician practice style may be a more important variable than length of stay in efforts to control health care costs. For example, the hospitalization rate for hysterectomy, tonsillectomy, and prostatectomy showed variations 20 to 30 times that of such conditions as hip fractures and inguinal hernias in the states of Maine, Iowa, and Maryland. When physicians have been presented with data on relative variations in practice, they have voluntarily modified their behavior in ways that led to a reduction in medical costs with no decrease in quality of care. NCHSR is taking further action by cosponsoring with the American Medical Association a conference to further educate the practicing physician about small area variations.

Further study of variations in medical care also is an important step to take. New research resources could be effectively used to explore such issues as:

- Extent and magnitude of variation in medical practice as it affects the Medicare-eligible population.
- Means to coordinate and integrate the collection of sound epidemiologic data to explain variations in practice.
- Role of differences in practice organization and management, reimbursement, professional education, technology, consumer information, and medical standards.
- Linkage between specific diagnostic and treatment practices and outcome.

NATIONAL VITAL STATISTICS

Mr. Conte. Speaking of letters, I have also received a letter from the Commonwealth, indicating that the National Center for Health Statistics doesn't have enough funds to purchase an entire year's statistical data from all the States. What is the situation here, and how much of the increase in NCHS in the FY 1987 budget is to take care of this problem?

Dr. Macdonald. As a result of the FY 1986 sequestration, NCHS is adjusting the contract period with the States in the National Vital Statistics System, through which the Federal government funds a share of the costs incurred by these States in producing vital statistics for national use (births, deaths, cause of death, infant mortality, etc.). Normally, a full 12 months of data are purchased each fiscal year; during FY 1986, however, data will only be purchased through the month ending December 31, 1986, resulting in a shorter contract for some States. This contract adjustment will result in one-time savings in FY 1986. Of the FY 1987 budget increase, NCHS will use $1.9 million to fund each of those States for a full year at the end of their FY 1986 contracts, and there will be no effect on program operations.

BLACK HEALTH TASK FORCE

Mr. Conte. As a result of the Task Force on Black and Minority Health, I believe an office was set up with something like $3 million in initial funding. I have never been able to figure out where this office is located and where the initial funding was taken from. Can you fill me in? Where is the proposal for this office reflected in the FY 1987 budget, and what do you anticipate its activities will be?

Dr. Macdonald. The Office of Minority Health was established in the Office of the Assistant Secretary for Health just after the Fiscal Year 1987 budget was completed. Since all PHS agencies support activities which address minority health issues, it was decided that funding for the new office would be identified from funds available in the PHS agencies in Fiscal Years 1986 and 1987.

The Office of Minority Health is a coordinating office which will serve as a focal point in redirecting the efforts of the Department aimed at achieving the objectives of improved health for blacks and minorities. The Office, working closely with PHS agencies and other DHHS components, will:

- Establish near-term and long-range objectives for DHHS health activities addressing minority populations;
- develop reporting and monitoring requirements for those objectives;
- organize and plan specific activities to meet minority health needs and monitor the DHHS budget to assure an appropriate share of funds is devoted to minority health problems;

BEST [illegible] AVAILABLE

- provide ongoing technical assistance to States and work closely with public and private sectors to assure minority health issues are addressed;
- serve as a resource in the promotion, investigation, development and implementation of innovative health care models culturally unique to minority populations;
- conduct, review, and develop strategies to improve the availability and accessibility of health professionals to minority communities;
- conduct, sponsor, and facilitate conferences on minority health;
- assure that steps are taken to improve data sources and integrate data systems reflecting minority populations; and
- facilitate research in and foster public awareness of research in factors affecting minority health.

WORLD HEALTH ORGANIZATION

Mr. Conte. Who's going to the World Health Organization's Annual convocation this year, and when is it being held (usually in May)?

Dr. Macdonald. The 39th World Health Assembly meets in Geneva, Switzerland, May 5-16, 1986. While Secretary Bowen tentatively plans to head the U.S. delegation, the delegation members have not yet been named. When the composition of the delegation is known, probably in mid-April, we will provide you with their names and titles.

SPECIAL FOREIGN CURRENCY PROGRAM

Mr. Conte. Last year, no special foreign currency funding was requested to fund activities under our international multilateral and bilateral cooperative agreements. In response to a question that I asked last year, as to whether there was sufficient funds already available the answer indicated that there were sufficient funds available to fund your "highest priority projects" in FY 1986. Was that a shorthand way of saying you didn't have enough funds to carry out all activities in the Office of International Health?

Dr. Macdonald. No. The Special Foreign Currency Appropriation is a no-year appropriation and at the beginning of FY 1986 there was a carryover balance in that account of $5,887,852. This amount was available because some countries had gone off the Treasury Department's excess currency country list. Thus, we had not been able to use the money in earlier years at the rate we had expected. The carryover balance is adequate to fund our priority projects in the designated countries in FY 1986. Only Burma, Guinea, Pakistan and Poland are on the excess currency country list this fiscal year. These resources are, however, important for the support of collaborative activities with these countries.

Mr. Conte. There is again no budget request in FY 1987. What does that mean with regard to our international health activities?

Dr. Macdonald. No request was submitted because we expect to have a carryover balance for FY 1987 that will be sufficient to continue the program activities that are funded from this account.

I should note that the full range of bilateral program activities of the PHS, such as those with China, Italy, Japan, the U.S.S.R., and others are, for the most part, supported through the program budgets of the PHS agencies. They must compete for support, on the basis of scientific excellence and the opportunities that are presented, with domestic programs. The Special Foreign Currency Program is a unique resource, which is, in general, not available for the broader range of international activities. Over the past few years, some alternative resources for support of bilateral activities have emerged. These have included the new U.S.-India Fund for Cultural, Educational and Scientific Cooperation and the funds for scientific cooperation under the U.S.-Spain Treaty of Friendship and Cooperation.

OFFICE OF INTERNATIONAL HEALTH

Mr. Conte. Why don't you tell us a little bit about the activities of the Office of International Health -- how many people are there, and what some of the good things it is up to are -- and why don't we ever hear about them and their activities?

Dr. Macdonald. The Office of International Health which is located and funded in the Office of the Assistant Secretary for Health is a staff office with 11 employees which is responsible for, among other things, recommending to the Assistant Secretary for Health and the Office of the Secretary policy and direction for international health and providing policy guidance and coordination for the international activities of the PHS agencies.

Since its creation, OIH has served as the official liaison office, on behalf of the PHS, for the U.S. Government with the World Health Organization (WHO) and the Pan American Health Organization (PAHO), which serves as the WHO Regional Office for the Americas. The Office is also responsible for assuring fulfillment throughout the year of U.S. obligations as a member government of the United Nations system and of the specialized UN Agencies, including WHO, the United Nations Children's Fund, and others. This includes development, in cooperation with the Department of State, policy recommendations on issues which come before the governing bodies of the UN agencies and promoting U.S. interests and policies in those organizations.

OIH plays a key role in the overall guidance of the bilateral health programs. The OIH staff works with the PHS agencies in assuring a coordinated approach to the development of new relationships and in the implementation of existing relationships, such as those with the People's Republic of China, Egypt, India, Japan, Mexico, Israel, the U.S.S.R., Spain and Italy, to name a few.

The Office works closely with the Agency for International Development to assure the effective engagement of PHS and AID resources. An important activity, initiated in FY 1985 with AID, is directed toward development of new or improved vaccines that will enhance child health programs. Thus far, AID has provided $5 million to PHS for this work. All projects supported with these funds complement and strengthen PHS programs. For example, this funding had enabled the U.S. to undertake a field trial in Venezuela of a new vaccine for diarrhea caused by rotavirus. We have also conducted, through the Pan American Health Organization, a field trial of a unit-dose delivery system for measles vaccine. A field trial of a new vaccine for typhoid is under way in Nepal.

Scientific benefits resulting from international work are presented regularly in scientific journals and, for some international activities, special reports are prepared. For example, there is an annual report on the U.S.-Japan Cooperative Medical Science Program.

Clearly, the benefits of international cooperation are manyfold, and international cooperation in health is critical to meeting our domestic health objectives, as well as for humanitarian reasons.

Mr. Conte. For the record, provide the materials requested by the Senate in this area.

Dr. Macdonald. The PHS Report on International Health Activities 1985, prepared for the Senate Appropriations Committee, follows.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Public Health Service

REPORT ON

INTERNATIONAL HEALTH ACTIVITIES
1985

Prepared for the
Senate Appropriations Committee

February 3, 1986

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Public Health Service

International Health Activities

TABLE OF CONTENTS

PAGE

Office of the Assistant Secretary for Health 1

Alcohol, Drug Abuse and Mental Health Administration 6

Centers for Disease Control 9

Food and Drug Administration 12

Health Resources and Services Administration 14

National Institutes of Health 16

Appendix A - Bilateral Cooperative Relationships of the U.S. Public Health Service as of September 30, 1985

Appendix B - National Institutes of Health Annual Report of International Activities, Fiscal Year 1984, John E. Fogarty International Center for Advanced Study of the Health Sciences

Appendix C - Estimated Expenditures on International Health Activities, FY 1985

INTERNATIONAL HEALTH ACTIVITIES
OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

Office of International Health

The Office of International Health (OIH) is a small staff office within the Office of the Assistant Secretary for Health. The Office is responsible for, among other things, recommending to the Assistant Secretary for Health and the Office of the Secretary policy and direction for international health and providing policy guidance and coordination for the international activities of the Public Health Service (PHS) Agencies.

Since its creation, OIH has served as the official liaison Office, on behalf of the PHS, for the U.S. Government in relationships with the World Health Organization (WHO) and the Pan American Health Organization (PAHO), which serves as the WHO Regional Office for the Americas. The Office is also responsible for assuring fulfillment, throughout the year, of U.S. obligations as a member government of the United Nations system and of the specialized UN Agencies. These Agencies include, in addition to WHO, UNICEF, the UN Development Program, the UN Economic and Social Council, the UN Fund for Population Activities, the UN Environment Program and the UN Food and Agriculture Organization. This responsibility includes development, in cooperation with the Department of State, of policy recommendations on issues which come before the governing bodies of the UN Agencies.

OIH plays a key role in the overall guidance of the bilateral (country-to-country) health programs of the Public Health Service. This involves provision of leadership in developing, with other countries, new agreements and programs, monitoring activities to assure consistency with U.S. and Departmental policy, and providing leadership for the various bilateral working groups (e.g. U.S.-China Joint Health Committee). The PHS Agencies currently cooperate with 56 countries under 67 formal agreements (see appendix A). These include programs with such key countries as the People's Republic of China, Egypt, India, Japan, and the U.S.S.R. The following are selected highlights during Fiscal Year 1985:

- People's Republic of China (PRC) - Collaborative health activities, under the program initiated in 1979, continued throughout 1985. The Health Protocol with the PRC encompasses 10 areas of scientific activity: infectious and parasitic diseases; cancer; cardiovascular disease; public health and health services research; biomedical information science; immunology; medical genetics; reproductive physiology and family planning techniques; mental health; and food and drugs, including pharmacology. U.S. participants are drawn from PHS laboratories as well as from extramural institutions. The work conducted in China, thus far, consists largely of epidemiological studies, clinical trials, and collaboration on health status surveys. A number of Chinese scientists are receiving research experience in PHS laboratories and a growing number of publications are being produced.

- India - In April 1985, at the U.S.-India Science and Technology Subcommission Meeting in New Delhi, the Health and Medical Sciences Working Group developed and recommended the essential elements for a new program of cooperation on vaccine development. The concept for this program was developed further during May and June; and, the U.S.-Indo Vaccine Action Program (VAP) was announced by President Reagan and Prime Minister Rajiv Gandhi in July, during the Prime Minister's state visit to the United States. On the U.S. side, the VAP will be carried out through a collaborative relationship between the Department of Health and Human Services and the Agency for International Development. The scope of the VAP is broad, ranging from basic research through delivery issues, including vaccine quality control. Issues expected to receive priority attention include diarrheal diseases, hepatitis and rabies.

- Japan - The Department's bilateral relations in the health field with Japan are encompassed under several distinct agreements. These include a Cooperative Medical Science Program, which has a strong emphasis on tropical diseases; Cooperative Cancer Research; Vision Research; a MEDLARS Agreement with the National Library of Medicine; and cooperation under an umbrella science and technology agreement, the latter including such areas as mental health and alcoholism, and laboratory animal quality control. The U.S.-Japan Cooperative Medical Science Program celebrated its 20th anniversary. Under this program , nine areas have been designated for joint research: cholera, leprosy, malnutrition, parasitic diseases, tuberculosis, viral diseases, environmental mutagenesis and carcinogenesis, viral hepatitis, and immunology. Each country is responsible for providing the necessary financial support for its own scientific work.

- Mexico - The cooperation on the U.S.-Mexico Border, which has been ongoing through the Pan American Health Organization (PAHO) since 1942, had an increase in activities in 1985. Over 20 training courses were held in areas such as rabies control, food sanitation, maternal and child health, tuberculosis and VD control. Plans are under way and initial steps have been taken to organize a laboratory network along the Border. Similarly, development of a university network is under way, with the goal of improving the coordination of research being conducted and dissemination of the results of that research. Funding for these activities comes primarily from PAHO, with small amounts of funds or in-kind resources from the PHS Agencies and the Mexican Ministry of Health. Because of the increasing influx of people in the northern border area of Mexico (at the same time that Mexico is finding it more difficult to provide funds and supplies to its states), these programs of training and cooperation are of great importance, both in U.S.-Mexican relations and for dealing with the anticipated increased burden on the health care systems along the Border.

o Israel - Although economic conditions did not permit development of new initiatives during the year, the Department and the Ministry of Health reaffirmed their commitment to seek opportunities to deepen bilateral cooperation in health by renewing, for a second five-year period, the U.S.-Israel Memorandum of Agreement in Health. The renewal of the Health Agreement was signed in May, 1985, by the Secretary of HHS and the Israeli Health Minister. Additionally, the U.S. Surgeon General, at the invitation of the Israeli Health Minister, made a highly successful visit to Israel to help launch that nation's efforts to inform the public about the health consequences of smoking. Under the Health Agreement, a binational symposium on technology assessment was held in Israel in November 1985.

o U.S.S.R. - Cooperation with the Soviet Union continued under the Health and Artificial Heart Agreements. Although no high-level meetings have taken place since 1979, by decision of the National Security Council, exchanges and collaborative research have proceeded at the working level. Each side uses its own resources to support the research conducted in its own country, transport its scientists to the other country, and to host visiting scientists. On both sides, the collaborative activities are designed to complement and support the domestic health mission. In the area of cardiovascular diseases, collaborative risk factor studies are being conducted, as are basic research studies on the heart, biobehavioral studies of hypertension and sharing of data on the clinical treatment of advanced coronary heart disease. Priority areas in cancer have been reassessed and now individual exchanges are being promoted with a focus on cancer treatment and prevention. In environmental health, joint studies on the biological effects of microwave radiation, static, and low-frequency electromagnetic radiation are being carried out. In the areas of influenza, acute respiratory diseases, and viral hepatitis, a program review was held in April, 1985, with a Soviet delegation of three in attendance. Both sides are pleased with the collaboration, which has permitted the rapid exchange of newly isolated influenza viruses, reagents, and standards, as well as the conduct of joint studies made possible through exchange visits. During the November, 1985, Summit Meeting, President Reagan encouraged a broadening of cooperation in the health sciences. Possibilities for doing so are being explored within the PHS.

The Office has continued its close cooperation with the Agency for International Development, with special emphasis on coordination of activities and resources where common goals are identified. In late FY 1984, a Participating Agency Services Agreement (PASA), to provide for a program of vaccine development, was signed between OIH and the Office of Health, AID. Under the Vaccine Development PASA, over $5 million has been provided by AID for research on vaccines of special importance to the developing world. Among the vaccines under study are some which are of substantial importance domestically as well. These include an acellular pertussis vaccine and a rotavirus vaccine.

National Center for Health Statistics

The National Center for Health Statistics (NCHS), through its Office of International Statistics, maintains programs of research, analysis and technical assistance. NCHS also maintains the World Health Organization (WHO) Collaborating Center for Classification of Diseases for North America, which is closely involved with the work of other WHO Centers in France, Brazil, Russia, Venezuela and England. NCHS programs are supplemented by informal work with experts from other countries, many of whom visit the United States to learn directly about NCHS' activities in the collection and dissemination of health statistics.

NCHS has initiated the International Collaborative Effort (ICE) on Perinatal and Infant Mortality to carry out comparative studies intended to elucidate the factors responsible for infant mortality in the United States and other industrialized nations. The results of these activities are expected to provide guidance for Public Health Service programs and activities designed to improve infant health and reduce the disparities that currently exist between racial, ethnic and socioeconomic groups in the United States. Research proposals and activities are developed and carried out by the ICE Planning Group, whose members are from the National Center for Health Statistics, the Center for Environmental Health of the Centers for Disease Control, the Division of Maternal and Child Health of the Health Resources and Services Administration, and the National Institute of Child Health and Human Development of the National Institutes of Health, as well as the Association for Vital Records and Health Statistics. This group also includes two eminent researchers from each of eight countries: Denmark, England and Wales, the Federal Republic of Germany, Israel, Japan, Norway, Scotland, and Sweden.

For many years, NCHS has supported collaborative projects through the Special Foreign Currency Program. Current activities include projects in Egypt (development of health profiles of the Egyptian population and the cancer registry for the metropolitan Cairo area), India (iron deficiency anemia in rural India and a longitudinal study of a prospectively studied birth cohort) and Pakistan (analysis and design of a model health statistics information system). NCHS is also engaged in activities under a bilateral agreement between the United States and Israel and in informal collaborative relationships with institutions in France, the Federal Republic of Germany and Poland.

INTERNATIONAL HEALTH ACTIVITIES OF THE ALCOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION

The major objectives of the Alcohol, Drug Abuse and Mental Health Administration's (ADAMHA) international activities are: (1) to further the domestic goals of the Agency through cooperative and collaborative activities with other countries; (2) to support U.S. foreign policy objectives; and (3) to increase other countries' capabilities to deal more effectively with their alcohol, drug abuse and mental health problems. Each of ADAMHA's three Institutes is presently engaged in international health activities.

Alcohol Abuse and Alcoholism

The National Institute of Alcohol Abuse and Alcoholism (NIAAA) seeks to advance its goals through international collaboration, recognizing that alcohol consumption and its attendant problems are universal, societal phenomena, and that true understanding of the problem requires an understanding of international and intercultural variations. At the Thirty-second World Health Assembly in 1979, a resolution addressing alcohol-related problems was passed. In brief, this resolution recognizes that alcohol-related problems "rank among the world's major public health problems" and urges governments to take a number of prevention, treatment and training efforts.

In 1983, NIAAA was designated as a WHO Collaborating Center for Research and Training. As a Collaborating Center, the Institute facilitates WHO collaborative linkages with the National Alcohol Research Centers in the United States, with individual research investigators funded by NIAAA as well as consultant experts, research scientists and senior staff within the Institute. Areas of cooperation include exchange of scientific information and statistical data, exchange of research and other professional personnel in work/study programs, training of personnel from developing countries, particularly to develop skills in epidemiological studies and the treatment and management of alcohol dependent persons. NIAAA also cooperates with WHO and other member governments in collaborative projects directed toward the development and application of research instruments and methods, especially in the clinical and epidemiological areas.

NIAAA has an extensive program of bilateral cooperation. With Finland, there is a joint project to conduct a comparative analysis of data from several countries on teenage drinking and related problems. An international workshop was held with Finland in Washington, D.C. in 1985. The program with Mexico includes this the Alcohol Research Center in Berkeley, California: a study of drinking patterns and problems in the Morelia area in Mexico and a comparative analysis with Mexican-Americans in California to assess differences in cultural and sociological patterns. In addition, through the U.S.-Spain Science and Technology bilateral program, a comparative study is being conducted in the Madrid area (using the same research protocols) and a comparative analysis is planned with U.S. Hispanic data as well as with the Mexican and Mexican-American populations.

A bilateral program also exists with Japan, including an alcohol epidemiological study of drinking patterns and problems, but also in relation to the "flushing" reaction, which is the result of a biologically adverse reaction to alcohol experienced by some Asian populations.

Drug Abuse

The National Institute on Drug Abuse (NIDA) works closely with the Department of State and various international organizations in conducting international information exchange and training activities, technical cooperation and assistance, and research. At the request of the Department of State or other governments, NIDA provides technical assistance on demand reduction, including treatment and prevention strategies, program planning and resource development. NIDA participates actively in the Drug Dependence Program of the World Health Organization and with other UN agencies. This includes provision of experts to serve on expert committees and in support of workshops and the provision of data and information on U.S. drug abuse and drug liability experience. NIDA also participates in the development of U.S. positions on drug scheduling decisions that come before the Commission on Narcotic Drugs and other international bodies.

Mental Health

The National Institute of Mental Health (NIMH) cooperates also with the World Health Organization. An important NIMH-WHO collaborative project seeks to achieve standardization of diagnosis and classification of mental illness. Procedures for standardization of research categories are being field tested in different countries. The Institute has also consulted with Latin American programs, at the request of the Pan American Health Organization. Members of the NIMH staff participated in the biennial meeting of the World Federation for Mental Health (WFMH), and are participating in the PAHO review of emergency preparedness procedures in Latin America.

A major part of the NIMH international program is implemented through bilateral agreements. This year, the collaboration with China continued through consultation visits to the mental health institutes in Beijing and Shanghai, where ongoing collaborative projects are being conducted. Studies have been completed on genetic markers and psychiatric treatments, and new work is being initiated on a cross-cultural study of depression. In Bangalore, India, a joint NIMH-National Institute of Mental Health and Neurosciences symposium was held on affective disorders; and, a study is under way on the relationship between mental illness and tropical disease. The cooperative program on the effects of psychotropic medication is continuing at the University of Pisa, with the establishment of a U.S.-European data base. The exchange of scientists with Poland has been resumed; and, in 1985, NIMH hosted to four psychiatrists from the Warsaw Psychoneurological Institute.

NIMH's international activities are focused primarily on knowledge development and dissemination. Research projects are supported through the regular grant program as well as Special Foreign Currency funds. A major vehicle for knowledge dissemination is participation in international meetings, which also provides the opportunity to establish cooperative activities to complement the work of NIMH's intramural laboratories. In addition, NIMH is a significant knowledge resource through its programs for foreign visitors, responses to written requests and advanced laboratory training opportunities. Consultation to other countries has been provided on such diverse topics as the development of the mental health system in Grenada and conceptualizing an AIDS behavioral research strategy for Denmark.

INTERNATIONAL HEALTH ACTIVITIES OF THE CENTERS FOR DISEASE CONTROL

The Centers for Disease Control (CDC) serves as the national focus for developing and applying disease prevention and control, environmental health, and health promotion and health education activities designed to improve the health of the people of the United States. In addition to international health activities conducted to protect the health of the American people, CDC's overall goals in its international health activities are:

- To reduce and prevent morbidity and mortality, and improve the quality of life;
- To help train persons from other countries in order to enhance public health capabilities elsewhere; and
- To conduct applied and operational research in order to develop new knowledge.

In addition to supporting selected international activities with its own resources, many of CDC's international efforts are conducted in collaboration with, and funded by, other U.S. agencies or international organizations, such as the Agency for International Development (AID), the World Health Organization (WHO), and the United Nations Children's Fund (UNICEF).

Under a Participating Agency Service Agreement (PASA) with AID, CDC is responsible for the implementation and coordination of the largest AID funded health project in Africa, entitled "Combatting Childhood Communicable Disease" (CCCD). The main objective of the project is to reduce childhood morbidity and mortality of African children through strengthening national capability to: (a) immunize infants and fertile age women, (b) treat diarrhea and dehydration with Oral Rehydration Therapy (ORT), (c) treat fever in children presumptively as malaria, and (d) provide malaria chemoprophylaxis to pregnant women. As part of the CCCD project, a multipurpose population-based survey known as the Mortality and Use of Health Services Survey (MUHS) was developed to be used in collecting data on children who are less than 5 years of age and on their mothers. Thus far, the CCCD project has been implemented through bilateral agreements with 12 African countries.

The Global Epidemic Investigation Services (GEIS) program has been designed to: (a) assist countries in developing national epidemiology training programs, (b) strengthen national epidemiological services, and (c) coordinate CDC's international epidemiological training activities. The program has been initiated in 5 areas (Thailand, Indonesia, Taiwan, Mexico, and Saudi Arabia). In Indonesia, CDC has been participating in the WHO sponsored Expanded Program on Immunization (EPI) and the Program on the Control of Diarrheal Diseases (CDD), striving to reduce morbidity (EPI) and mortality (EPI and CDD) due to diseases preventable by immunization and dehydration in Indonesian children.

CDC is also trying to be responsive to various kinds of crises by providing technical consultation internationally in natural and man-made disasters, including drought/famine, refugees/displaced persons, and aftermath of war and civil disturbance. At the request of, and reimbursed by such agencies and organizations, such as the Office of Foreign Disaster Assistance (OFDA/USAID), Bureau for Refugee Programs, Department of State, or the Pan American Health Organization (PAHO), CDC provides: (a) assessment of nature and extent of medical and health needs and nutrition status, (b) identification of vulnerable subpopulations, (c) recommendations on specific relief, outbreak control and preventive measures, and (d) participation in intervention activities. CDC personnel were involved in assessing nutritional status in most of the drought affected Sahel countries last year. CDC, responding to a request from the Indian government, fielded a team to consult on the public health implications of the chemical leak at the Union Carbide plant in Bhopal, India. Early in FY 1985, CDC published a monograph that summarizes the experience in dealing with the Indochinese refugee crisis in 1979-1980.

CDC is actively involved in joint collaborative activities under the Special Foreign Currency Program (SFCP) and bilateral health agreements with countries like the People's Republic of China, the Soviet Union, Finland, and Spain.

Under an interagency agreement, CDC provides epidemiologic and technical consultation to the Peace Corps Office of Medical Services, which provides for the health care of Peace Corps volunteers.

CDC staff participated in WHO Working Groups (Maternal and Child Health, Bacterial and Venereal Infections) to develop simplified approaches at the primary health care level for sexually transmitted diseases (STD) control in developing countries.

In collaboration with other U.S. Public Health Service (PHS) Agencies, CDC has been actively involved in the surveillance of and research into Acquired Immuno Deficiency Syndrome (AIDS). An International Conference on AIDS, sponsored by CDC, NIH, FDA, ADAMHA, HRSA, and WHO was held at the World Congress Center in Atlanta, Georgia, in April 1985. The purpose of the conference was to: (a) review strategies for the prevention and control of AIDS, (b) exchange information on screening and diagnostic tests for AIDS, and (c) on the epidemiology, virology, immunology, clinical manifestations, and treatment of AIDS. CDC and NIH have a collaborative project with the Ministry of Health in Zaire on AIDS. The activities include studies to establish estimates of the incidence of AIDS and HTLV-III/LAV positivity, the prevalence of AIDS in various population groups, the risk factors for acquiring AIDS and factors responsible for transmission of AIDS.

Under the Resources Support Services Agreement (RSSA) with AID, CDC has been providing technical assistance in the area of family planning, at the request of AID Missions in various countries.

INTERNATIONAL HEALTH ACTIVITIES OF THE FOOD AND DRUG ADMINISTRATION

The Food and Drug Administration (FDA) is a scientific/regulatory agency with responsibility for regulating U.S. domestic commerce, importation, and exportation of most human and animal foods and drugs, cosmetics, biologics, medical devices, radiation-emitting products, and diagnostic products. FDA's prime responsibility is to protect the health and welfare of the American consumer through effective administration of the Federal Food, Drug and Cosmetic Act and other related legislation to assure the safety and quality of the products and processes it regulates.

FDA is widely recognized as the leading food and drug regulatory agency in the world, and its policies and actions have significant effects on international trade in foods, drugs, and other regulated products, and on national food and drug policies in other countries. In view of this, it is important that FDA be sensitive to the international implications of its domestic actions, to explain adequately to representatives of foreign governments the reasons for its actions, to provide technical assistance to foreign governments wishing to improve the quality and safety of their foods and drugs, and to provide advice (on U.S. legislation and policies) to foreign manufacturers exporting FDA regulated products to the United States.

FDA's international activities fall into three basic categories: (1) regulatory/compliance, (2) international standards, (3) development and liaison.

Regulatory/Compliance:

The principal regulatory objectives of FDA in the international arena are to assure that all imported goods conform to the same standards of safety, quality, purity and efficacy as domestic goods. FDA employs several major regulatory/compliance strategies to assure that imported products meet U.S. standards. These include: import surveillance at the port of entry; inspection of foreign food, drug, medical device and biologics manufacturing establishments which export products to the United States; and written memoranda of understanding (MOU) with other countries. These MOUs address, among other things, good manufacturing practices, good laboratory practices, and safety, sanitation and quality control matters.

FDA has formalized agreements with numerous countries, including Australia, Belgium, Canada, Denmark, France, Iceland, Japan, Korea, Mexico, the Netherlands, New Zealand, Sweden, Switzerland, and the United Kingdom.

Technical Assistance:

Through bilateral cooperative agreements, FDA provides assistance to foreign governments to strengthen their food and drug control activities. Activities include information sharing and specific collaborative projects for the benefit of both countries. To help assure compliance, FDA works with foreign officials to develop administrative, laboratory and field investigative skills.

Development and Liaison:

Close to 400 foreign officials and scientists, representing more than 50 countries, visit FDA annually. Most of these visits are short-term in nature. Longer-term visitors are provided for under WHO Fellowships, the FDA Visiting Scientist Program, AID Participant Training Programs, and other mechanisms.

FDA conducts problem-oriented workshops, related to significant import problems, in order to help foreign countries comply with specific FDA regulatory requirements.

Cooperation with International Organizations:

FDA cooperates closely with international organizations, including the Food and Agriculture Organization (FAO), World Health Organization (WHO), United Nations Environmental Program (UNEP), and the International Labor Organization (ILO). FDA provides a small annual grant ($50,000) to support meetings of the Joint FAO/WHO Expert Committee for Food Additives and the Joint FAO/WHO Meeting on Pesticide Residues, both of which provide extremely valuable international recommendations, which are used in domestic FDA regulatory programs. The International Program on Chemical Safety (IPCS) is a cooperative program of three UN Agencies (WHO, UNEP, ILO), and it is the international focal point for expertise and discussion associated with international problems arising from the worldwide use of chemicals. FDA provides scientific documents and participates in various expert committee meetings on the safety of food and on color hazards in food. This is an ongoing activity that not only benefits FDA but has provided many developing nations with evaluations for their national policies concerning food additives and food contaminants.

FDA is assisting with the preparation of papers in connection with the U.S. Government's position on Drug Scheduling and for the U.S. Delegation to the UN Commission on Narcotic Drugs.

INTERNATIONAL HEALTH ACTIVITIES OF THE HEALTH RESOURCES AND SERVICES ADMINISTRATION

The Health Resources and Services Administration's (HRSA) current involvement in international health encompasses a broad spectrum of projects and activities, including: (1) international health program planning, evaluation, and assessment; (2) conduct of special studies on health resources and services issues; (3) technical assistance through AID and Multilateral organizations; and (4) liaison with international organizations. These programs have evolved through HRSA's leadership role in the U.S. Government for health planning, health services delivery and manpower development.

HRSA has a number of active overseas projects, financed under the PHS Special Foreign Currency Program. The following are illustrative examples:

- In Egypt, a project to improve emergency medical services
- In India, a study of tranfer factor in the management of leprosy. The possiblity of a field trial of a leprosy vaccine is being explored.
- In Tunisia, an epidemiological study of trachoma, a blinding eye disease.

HRSA is an important resource for technical assistance for the Agency for International Development. A HRSA Environmental Engineer is currently on assignment for AID (under a reimbursable services agreement) in Ecuador. HRSA staff are also sought by the World Health Organization and the Pan American Health Orgnaization for short-term overseas assignments. These experiences not only assist the concerned foreign countries but enhance the skills of the involved HRSA staff.

The Gillis W. Long Hansen's Disease Center, which provides world leadership in the control and study of leprosy, has been designated as a WHO Collaborating Research Center. The Center is an important resource for training of experts from other countries. These trainees come under the auspices of their own governments or home institutions, WHO, or AID.

HRSA has an agreement with the Government of Saudi Arabia for the planning and design of an emergency medical services (EMS) system for that country. All costs are being borne by the Government of Saudi Arabia. HRSA's long experience in facilitating the development of EMS systems domestically, as well as the Agency's extensive contacts with EMS experts throughout the United States, have made it an important focus for EMS cooperation internationally.

During 1985, a working group, comprised of representatives of the PHS Agencies and chaired by the Administrator of HRSA, was established to oversee the PHS' involvement in providing emergency health services assistance to the drought stricken areas of Africa. HRSA established a clearinghouse to identify PHS personnel who could provide emergency services for assignment of up to 90 days. Over 400 PHS personnel submitted applications to be considered for these assignments. Fourteen PHS medical epidemiologists, nurses, sanitarians and other expert staff have now served in Chad, Ethiopia and the Sudan. The expenses associated with these assignments were reimbursed by the Department of State and the Agency for International Development. HRSA manages the WHO Fellowship Program on behalf of the Public Health Service. This involves announcing the opportunity for WHO Fellowships to the U.S. health science community and managing a process for the selection of the U.S. participants in the Program. This responsibility also involves the arrangement of programs in the United States for WHO Fellows from other countries. The latter is a responsibility of the U.S. Government as a member country of WHO.

INTERNATIONAL HEALTH ACTIVITIES OF THE NATIONAL INSTITUTES OF HEALTH

As the principal biomedical research and biomedical communications agency of the Government, the National Institutes of Health (NIH) must engage in international cooperation to achieve its objectives. The Bureaus, Institutes and Divisions of NIH are engaged in a broad, complex range of activities with other countries and with multilateral organizations. The programs and activities include:

- o Research grants and contracts awarded to foreign institutions as well as awards to domestic grantees for research having an international component.

- o Scientist exchanges, including the Visiting Scientist and Guest Worker programs of the NIH Institutes, as well as the several exchange programs administered by the Fogarty International Center. The latter include: the Scholars-in-Residence Program; the International Research Fellowship Program; the WHO/NINCDS/FIC International Neurosciences Fellowships; the Senior International Fellowship Program; Foreign Fellowships for U.S. Scientists; and Individual Health Scientist Exchange Programs with several countries, including the U.S.S.R., Romania, Hungary, Yugoslavia, and Poland.

- o Participation in international scientific meetings, activities of multilateral organizations (e.g. expert committees of the World Health Organization), and the like.

- o Collaborative projects under bilateral science and technology and/or bilateral health agreements with other countries. NIH is currently engaged in collaborative activities with 32 countries under 56 agreements. Key countries include the People's Republic of China, Egypt, Franbe, India, Italy, Japan, and the U.S.S.R.

- o Studies of important international health issues. This includes international symposia. Symposia topics thus far have included: poliomyelitis control, yaws and other endemic treponematoses, prevention of congenital rubella infection, and the role and significance of international cooperation in biomedical sciences. A symposium on rabies will be held in late 1986.

It must be emphasized that the international biomedical research activities supported by NIH benefit U.S. health by expanding the base of knowledge required for solution of domestic health problems and by stimulating other countries to undertake research of potential value to U.S. public health pursuits.

Because NIH's international involvement is so extensive, a copy of the National Institutes of Health Annual Report of International Activities, Fiscal Year 1984 is provided as Appendix B. The 1985 report will not be printed until later in 1986.

A number of significant research advances have been made under bilateral agreements coordinated by the Fogarty International Center. The following are illustrative examples:

The results of an 8-year study, supported by the National Institute of Neurological and Communicative Disorders and Stroke (NINCDS) and involving 71 medical centers in North America, Europe and Asia, showed that the extracranial/intracranial (EC/IC) bypass operation, a neurosurgical procedure that directs blood past occluded brain arteries, should be abandoned for safer, equally effective medical alternatives. This study, which has demonstrated to the surgical community that controlled clinical trials of a surgical procedure are ethical and feasible, has set an international standard for the evaluation of all surgical procedures.

The results of a 3-year project, conducted by NINCDS and Italian investigators, revealed that people whose brothers or sisters have any form of dementia may be eleven times more likely than others to develop Alzheimer's disease, and that babies born to mothers over age 40 may be at greater risk for dementia later in life.

Under the Medical Science and Public Health Cooperative Agreement with the Soviet Union, cooperative research was conducted on the effects of microwave radiation and low frequency electromagnetic fields on the nervous, cardiovascular and reproductive systems. Additionally, a collaborative research protocol was developed which will identify: (a) more reproducible biological endpoints for assessing the effects of non-ionizing radiation, and (b) more sensitive indicators of biological alterations. These joint experiments will serve to resolve the long-standing discrepancy between U.S. and Soviet safety standards for electromagnetic radiation.

Longitudinal studies supported by the National Institute of Child Health and Human Development in two developing countries (Guatemala and Bangladesh), and a third study supported by the National Center for Health Statistics in India, have shown that a mother's nutritional status before she conceives and the amount of weight she gains during pregnancy have an important impact on pregnancy outcome. When other factors, such as maternal age, parity and socioeconomic status are held constant, women who weigh more before conception and gain more weight during pregnancy are more likely to have live births.

Scientists at the National Heart, Lung and Blood Institute and the Institut National de la Sante et la Recherche Medicale, Paris, have initiated collaborative research on the pathology of interstitial lung disorders in pulmonary circulation. This productive cooperative effort is being conducted under an inter-institutional memorandum of understanding.

U.S. and Japanese scientists, working collaboratively, published important new findings on relationships between dietary protein and the incidence of hypertension and stroke. Results derived from research using a strain of genetically stroke-prone spontaneously hypertensive rats indicate that modification of dietary protein influences the calcium metabolism of heart muscle and, indirectly, the development of hypertension. This research provides one of the few clues to the biochemical basis of hypertension.

EXPENDITURE ESTIMATES:

A summary of estimated expenditure for international health is provided in Appendix C.

Appendix A

BILATERAL COOPERATIVE RELATIONSHIPS OF THE U.S. PUBLIC HEALTH SERVICE AS OF SEPTEMBER 30, 1980

Australia (FDA)	Under agency-to-agency agreement, consumer protection and regulation.
Austria (NIH)	Under Agency workplans, cooperation through the Standing Committee of the European Medical Research Council's exchange of information.
Belgium (FDA)	Under agency-to-agency agreement, consumer protection and regulation.
(NIH)	Under agency-to-agency agreement, cooperation in biomedical research
Brazil	Under agency-to-agency workplans, cooperation on infectious and tropical diseases with the Oswaldo Cruz Institute.
Canada (FDA)	Under agency-to-agency agreement, consumer protection and regulation.
(NIH)	Under agency-to-agency workplans, Cooperation in biomedical research
Denmark (FDA)	Under agency-to-agency agreement, consumer protection and regulation.
Egypt (PHS Wide)	Under Health Agreement, biomedical research, health services improvement, health statistics, drug and biologicals, health manpower development and medical education.
Finland (PHS Wide)	Under Health and Social Affairs Agreement, cooperation on occupational safety and health, alcoholism, development and testing of vaccines, health services research, food and drug consumer protection.
(FDA) consumer	Under agency-to-agency agreement, protection and regulation.
France (NIH)	Under government-to-government S & T Agreement, biomedical research and other cooperation in health sciences.
(FDA)	Under agency-to-agency agreement, consumer protection and regulation.
(NCHSR)	Under agency workplans, collaboration in health care utilization.
(NCHSR)	Under agency-to-agency workplans, cooperation in medical facility utilization.

BEST COPY AVAILABLE

FRGermany (PHS Wide)	Under Health Agreement, cooperation in biomedical research, other health sciences, and health information.
Hungary (NIH)	Under government-to-government S & T Agreement, biomedical research and exchanges, with emphasis on cancer.
Iceland (FDA)	Under agency-to-agency agreement, consumer protection and regulation.
India (PHS Wide)	Under Joint Cooperation Commission, health and biomedical sciences and under S & T Initiative cooperation on infectious diseases, vaccine development, prevention of blindness, mental health, reproductive physiology, and health information.
Ireland (NIH)	Under agency-to-agency workplans and through the European Medical Research Councils, cooperation in biomedical research.
Israel (PHS Wide)	Under Health Agreement, cooperation in health services research, health information, health policy issues, Food and Drug consumer protection, and biomedical research.
(ADAMHA)	Under agency-to-agency agreement, cooperation in alcohol abuse and alcoholism.
Italy (PHS Wide)	Under Health Agreement, cooperation on cancer, heart diseases, drug abuse, biomedical research, and other agreed areas.
Jamaica (NCHS)	Under agency-to-agency workplans, cooperation in vital statistics and health information.

Japan (HHS)	Under Joint Communique ([illegible]) and agreement with Department of State, which established the U.S.-Japan Cooperative Medical Science Program, cooperation on major health problems of Asian countries.
(HHS/NEI)	Under agency-to-agency agreement, exchanges and other cooperation in vision research.
(HHS/NCI)	Under agency-to-agency agreement, exchanges and other cooperation in cancer research.
(HHS/NIA)	Under agency-to-agency agreement, cooperation on problems of the aging.
(HHS/NLM)	Under agency-to-agency agreement, cooperation on indexing for biomedical information systems.
(HHS/NIH/ADAMHA)	Under Non-Energy S & T Agreement, cooperation on laboratory animal models, recombinant DNA, alcoholism and mental health, vaccine development, cardiovascular diseases, and toxicology.
(FDA)	Under agency-to-agency agreement, consumer protection and regulation.
(NCHS)	Under agency-to-agency workplans, cooperation in health statistics.
Korea (HHS/FDA)	Under agency-to-agency agreement, consumer protection and regulation.
Kuwait (HHS/NIH)	Under Health Agreement, intramural cooperation in agreed areas.
Mexico (HHS/NIH)	Under government-to-government S & T agreement, cooperation in agreed areas of health research.
(FDA)	Under agency-to-agency agreement, consumer protection and regulation.
(ADAMHA)	Under agency-to-agency agreement, cooperation on alcohol-related problems.
[illegible]	Through U.S.-Mexico Border Health Association, cooperation on border health problems.

Mexico (Continued)

(NIH)	Through U.S.-Mexico Border Health Association, cooperation in biomedical research and medical equipment maintenance.
Netherlands (FDA)	Under agency-to-agency agreement, consumer protection and regulation.
(NIH)	Under the European Medical Research Council, cooperation in biomedical research.
New Zealand (FDA)	Under agency-to-agency agreement, consumer protection and regulation.
Nigeria (PHS Wide)	Under Health Agreement, cooperation on health education, health information systems, occupational health, communicable disease, food and drug regulation.
Norway (FDA)	Under agency-to-agency agreement, consumer protection and regulation.
(NCHS)	Under agency workplans, cooperation in infant and perinatal health information.
(NIH)	Under agency workplans, cooperation in biomedical research through the Standing Committee of the European Medical Research Council.
Pakistan (PHS Wide)	Under S & T agreement, cooperation in the health sciences and health information.
Poland (PHS Wide)	Under Health Agreement, cooperation in broad range of biomedical and health sciences, health services utilization, and mental health.
Portugal (HRSA)	Under agency-to-agency agreement, cooperation on emergency medical services.
(NCHS)	Under agency-to-agency workplans, cooperation in vital and health statistics.

PRC (China) (PHS Wide)	Under Health Protocol, cooperation in public health, biomedical research, mental health, foods and drugs, disease control, health information systems and protection and regualtion.
(NIH)	Under agency-to-agency agreement with the Chinese Academy of Sciences, cooperation in the basic biomedical sciences.
(NIH)	Under agency-to-agency agreement with the Shanghai Brain Research Institute, cooperation in basic research.
Romania (PHS Wide)	Under Education, Cultural and S&T Agreement, exchanges of health professionals and other agreed activities.
(NIH/NCI)	Under institute-to-institute level agreement cooperation on cancer research.
Saudi Arabia (FDA, HRSA)	Under Joint Economic Commission, cooperation in food and drug field and on emergency medical services.
Scotland (NCHS)	Under agency workplans, collaboration in infant and perinatal health data.
Spain (PHS Wide)	Under Treaty of Friendship and Cooperation S & T Joint Committee, cooperation in health sciences.
Sweden (FDA)	Under agency-to-agency agreement, consumer protection and regulation.
(NCHS)	Under agency workplans, collaboration in infant and perinatal health data.
(NIH)	Under agency workplans, cooperation in biomedical research through the Standing Committee of the European Medical Research Council.
Switzerland (FDA)	Under agency-to-agency agreement, consumer protection and regulation
(NIH)	Under agency-to-agency agreement, exchanges in the biomedical sciences.
Taiwan (NIH)	Under agreement with the American Institute on Taiwan, cooperation in the biomedical sciences.

Thailand	Under government-to-government S&T agreement, cooperation in the biomedical sciences.
Tunisia (HRSA, NIH, NCHS)	Under Special Foreign Currency Program, collaborative health research (SFC).
United Kingdom (FDA)	Under agency-to-agency agreement, consumer protection and regulation.
(NCHS)	Under agency workplans, collaborative research on infant and perinatal health information.
(NIH)	Under agency workplans, cooperation in biomedical sciences through the British Medical Research Council.
USSR (PHS Wide)	Under Health Agreement, cooperation and professional exchanges in biomedical sciences and public health.
(NIH)	Under Artifical Heart Agreement, artificial heart R & D.
(NIH)	Under Environmental Protection Agreement, environmental research.
Venezuela (PHS Wide)	Under Health Agreement, cooperation in biomedical research, health services and other agreed areas.
Yugoslavia (PHS Wide)	Under S & T Agreement, collaborative research, principally in the biomedical sciences.
Zimbabwe (PHS Wide)	Under agreement with Department of State, cooperation in the health sciences.

(Appendix B- "The National Institutes of Health Annual Report of International Activities" is available from the Committee files)

APPENDIX C

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Expenditures on International Activities
FY 1985
(In thousands of dollars)

	Research Awards	Scientist Exchange Programs	Other Program Operations	Total
Office of the Assistant Secretary for Health	7,096*	91	890	8,077
Alcohol, Drug Abuse and Mental Health Administration	580	40	250	870
Centers for Disease Control	—	61	2,541	2,602
Food and Drug Administration	—	474	925	1,399
Health Resources and Services Administration	—	52	195	247
National Institutes of Health	30,588	27,256	9,300**	67,144**
TOTALS	38,264	27,974	14,101**	80,339**

Notes:
- * Obligations of U.S.-owned excess foreign currency under PHS Scientific Activities Appropriation, which is administered, on behalf of the Public Health Service, by the Office of the Assistant Secretary for Health
- ** Estimated Expenditures

Mr. Conte. Last year, an initiative on preventive health through handwashing was unveiled with some fan-fare. How is T-Bear doing?

Dr. Macdonald. The T-Bear clean hands initiative was originally conceived as a cooperative effort between HHS and the private sector. The basic plan was to develop the program with this Department's assistance and then transfer it to the private sector for continued management and implementation. This goal was successfully accomplished and the initiative is now being solely run by the private sector Scrubby Bear Foundation.

Some of the efforts completed included:

-- the establishment of 94 model hospital facilities where a full-fledged educational program on preventing infection through clean hands was instituted using the T-Bear theme;

-- an additional 800 private organizations representing day care, elementary schools, companies and hospitals enacted this program; and

-- a public service announcement was designed and developed for 800 television stations.

Mr. Conte. What other accomplishments in preventive health can you point to over the last year?

Dr. Macdonald. Progress in disease prevention and health promotion continues to be very positive, with so many indicators that it is difficult to list them all. Perhaps the most significant indicator of progress is continued reduction of death rates in every age group defined by the goals set forth in Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention. In fact, the 1990 goal of a 20 percent reduction in the death rate for children aged one to fourteen has already been achieved, based on 1984 provisional data.

In addition, we think these specific accomplishments are noteworthy:

o The National Heart, Lung, and Blood Institute has launched a National Cholesterol Education Program, modeled on its successful National High Blood Pressure Education Program.

o The Department, with the U.S. Department of Agriculture, has revised and reissued Nutrition and Your Health: Dietary Guidelines for Americans, representing basic nutrition policy.

o The Surgeon General recently issued his report on The Health Consequences of Smoking: Cancer and Chronic Lung Disease in the Workplace.

o The Office of Disease Prevention and Health Promotion (ODPHP) documented the unexpectedly fast expansion of health promotion programs sponsored by U.S. corporations at worksites.

- The ODPHP established the U.S. Preventive Services Task Force to recommend standard preventive services for clinical settings. This is a bi-national effort undertaken in partnership with the Canadian Task Force on the Periodic Health Examination.

- ODPHP prepared The Decision Maker's Guide to Reducing Smoking at the Worksite, which was published and widely distributed by the Washington Business Group on Health and the American Cancer Society.

- ODPHP launched the Healthy Older People public education program, aiming messages on nutrition, exercise, preventive clinical services, accident prevention, smoking cessation, and safe use of medications at older consumers and the professionals who serve them.

- The Task Force on Health Risk Assessment completed the first comprehensive analysis of health risk assessment methodologies published under the title Determining Risks to Health: Federal Policy and Practice (Auburn House, Inc., 1986).

- The Public Health Service carried out a midcourse review of the status of progress toward achieving the 1990 Health Objectives for the Nation. The review will be published in 1986.

- ODPHP and the Center for Health Promotion and Education (Centers for Disease Control) completed a major evaluation of school health curricula, documenting their effectiveness in modifying health behaviors of school-age children.

- ODPHP and the President's Council on Physical Fitenss and Sports completed major studies of the fitness level of American children and youth, documenting some cause for concern about trends in their health and fitness status.

NURSING HOME INSURANCE

Mr. Conte. Last year, you indicated that you were doing some work in the area of nursing home insurance. HOW SUCCESSFUL HAVE YOU BEEN IN WORKING TO MAKE THAT TYPE OF POLICY AVAILABLE IN THE PRIVATE SECTOR?

Dr. Macdonald. NCHSR's Long Term Care Studies Program has been working on a number of fronts to encourage the wider availability of private long term care insurance policies:

- The project has developed and analyzed survey data which revealed a widespread lack of understanding among Americans as to their insurance coverage for long term care. This survey data also explored consumer preferences for selected coverage features.

- The survey data also reveal that a reasonable market exists for long term care insurance.

- Actuarial studies conducted by NCHSR are currently being used by insurers to develop benefits design and premium structure for prototype policies.

- Project staff provide frequent technical assistance to a number of insurance companies who are in various stages of development of long term care policies. We estimate that at least ten new insurers have entered the market in the past year. One particularly exciting venture is a case managed long term care product being jointly developed by the Metropolitan Life Insurance Company and the Group Health Cooperative of Puget Sound.

TITLE X

Mr. Porter. What impact would the primary health care block grant proposal have on the administration of the Title X program? Would this result in a reduction in family planning services?

Dr. Macdonald. The FY 1987 proposal consolidates the Family Planning, Black Lung and Migrant Health categorical programs with the Community Health/Primary Care block grants into an expanded Primary Care Block grant at a funding level of $565.1 million. Under an expanded block grant States would assume responsibility for managing the program and allocating resources to best meet their individual needs. The objective of the block grant is to target resources according to State priorities.

We do not expect that an expanded Primary Care block grant would result in a reduction in family planning services. In addition, in FY 1986, a State would be required to expend for family planning, a percentage proportion equal to 80 percent of the proportion of funds received by the State for family planning in FY 1985 for all the programs subsumed in the block grant.

Mr. Porter. Former Secretary Heckler testified before Congressional committees in both 1984 and 1985 that she accepted the findings of GAO and HHS auditors that Title X family planning clinics do not use their federal funds for abortion procedures. She further stated that she saw no need for further law or regulation in this area. Do you agree with this assessment?

Dr. Macdonald. I support the President's position and current Federal law which states that no Federal funds shall be used for abortion services except to save the life of the mother. In addition, the Title X program prohibits funding of programs in which abortion is used as a method of family planning, and prohibits projects from promoting or encouraging abortion as a method of family planning.

I support program policies which are consistent with these prohibitions. Further, I believe it is essential that we ensure that the abortion prohibitions are being fully and universally honored. A better clarification of the separation between family planning services and abortion would enhance the Title X program, since effective family planning is always a better alternative than abortion. In managing the Title X program, I want to ensure that the program is administered consistent with both the letter and the spirit of the law.

Mr. Porter. Many of my colleagues in Congress felt that the Department of Health and Human Services went beyond congressional intent when it proposed parental notification regulations for Title X in 1982. Do you agree with this assessment?

Dr. Macdonald. In October 1983, a Federal Appeals Court ruled that the Department exceeded its statutory authority in issuing the parental notification regulations. The Solicitor General chose not to appeal the decision and the regulations have since been removed from the Code of Federal Regulations. While the courts determined that the regulations went beyond Congressional intent for the program, I support efforts to encourage parental involvement in family planning programs. I believe it is essential that Federal programs and policies recognize parents' primary responsibility for the care of their children and encourage active parental involvement in the decisions relating to the well-being of their children.

VOLUNTARY FAMILY PLANNING

Mr. Porter. Would you favor a policy mandating that government-funded family planning clinics promote only one form of contraception?

Dr. Macdonald. No. Users of family planning should have options in choosing the family planning method which best suits them. Requiring provision of a range of family planning methods insures that the client and the service provider can choose the method that the client prefers and which best suits the client's particular needs. I do think it makes sense to use single-service providers for complex specialized services like infertility and natural family planning, but services provided in this fashion are administered under subcontract from a full service Title X grantee.

TEENAGE PREGNANCY

Mr. Porter. The teenage pregnancy rate in the U.S. is currently 96 pregnancies per one thousand teenagers. This is double the rate in Canada and England and is the highest rate in the developed world. What do you foresee as the federal role in finding a solution to this alarming problem?

Dr. Macdonald. Teenage pregnancy is a complex problem with no easy solutions. There is a developing consensus that the root of the problem lies in the breakdown of traditional norms regarding premarital sexual activity and in the structure and functioning of the family. The solution requires that we, as a society, learn to deal with problems of family structure and functioning and that we develop in our children an enhanced ability to make responsible decisions and understand their responsibility for the effects of their actions.

In my view, the federal role in finding a solution for the problem should include the following:

- a continuing emphasis on primary prevention (postponement of sexual activity) for non-pregnant or non-sexually active teens;

- services for pregnant teens which focus on improving both health and social outcomes for the infant and the teen mother, encouraging responsible sexuality in the future, continued family involvement and support, and promotion of adoption as an option for pregnancy resolution;

- provision of contraception for sexually active teens (preferably while encouraging parental involvement in the decision);

- promotion of public policies which provide care and services without fostering family breakdown or creation of new single parent households headed by teenage mothers;

- encouraging more discussion and examination of social attitudes and practices--including Government, media, personal and family policies and behavior--which exacerbate the problem, including:

  - -- family structure and functioning;
  - -- family communication and involvement in sex education and contraception decisions; and,
  - -- role of the media, and particularly the way in which television glorifies early, frequent and out-of-wedlock sex.

Mr. Porter. What studies are currently being conducted on the problem of teen pregnancy?

Dr. Macdonald. The Office of Population Affairs, through the Adolescent Family Life (AFL) program, has funded 32 research projects in the areas of adolescent sexual behavior, adoption, services to pregnant and parenting youth, and adolescent pregnancy and parenting. Final reports have been received for 8 of these projects and the remainder are still in progress. Summaries of the research projects listed below are available from the AFL program.

ADOLESCENT FAMILY LIFE RESEARCH PROJECTS

Adolescent Sexual Behavior

Intrafamilial Sexual Socialization Patterns and Outcomes
Role of the Family in Deterring Unwed Parenting
Sex and Pregnancy Among Mexican-American Adolescents
Sexual Behavior Among Mexican Adolescents: A Follow-Up
Family and Institutional Factors in Adolescent Sexuality
Familial Communication and Adolescent Sexual Behavior
Parent, Peer, and Media Influence on Adolescent Sexual Behavior
Starting Early: The Antecedents of Early Premarital Intercourse
Short-Term Consequences of Adolescent Sexual Behavior
Concurrent and Later Correlates of Early Premarital Sex
Media Sexual Content and Adolescent Use and Perceptions
Premarital Sexual Relations Among Puerto Rican Youth

Adoption

Adoption and Parenting Decision-Making Among Adolescent Females
Orientation of Pregnancy Counselors Toward Adoption
Adoption Decision-Making in Pregnant Minority Youth

Adoption Decisions: Personal and Social Context
Adoption Behavior and the Propensity to Adopt in the U.S.
The Consequences of the Adoption Decision

Services to Pregnant and Parenting Youth

Resource Use by Pregnant and Parenting Adolescents
Adolescent Family Life: A Longitudinal Study
Developing Comprehensive Services for Teenage Parents
Contraceptive Use and Clinic Continuation Among Adolescents

Adolescent Pregnancy and Parenting

Fathers of Infants of Adolescent Mothers
Factors Influencing Quality of Adolescent Parenting
The Grandmother's Role in Teenage Parenthood
Social Support and Adolescent Childbearing
Parenting Among Low-Income Teenage Mothers
Longitudinal Study of Adolescents and Their Children
Psychological Impact of Pregnancy for Rural Adolescents
Attachment Across Generations in Families of Adolescents

Child Development: Infants of Teenage Mothers

Teen Mothers: Maternal Care and Child Development
Teen Mothers and Attachment

Mr. Porter. What, if any, education programs address prevention of teen pregnancy?

Dr. Macdonald. The Adolescent Family Life (AFL) program is currently funding twenty-three prevention projects and thirteen combination care and prevention projects that are designed to develop effective approaches to encouraging unmarried teens to postpone sexual activity and to encourage parents to assume the role of primary sex educators of their children. Many of these projects are developing their own educational programs that focus on improving parent/child communication.

There is no national sex education policy in the U.S. that is directed toward prevention of teen pregnancy. Decisions on sex education curriculum are made in individual States and school districts which conforms to the general policy of State and local control over education policy and curricula. This insures that decisions about sex education are made with maximum input from parents and generally reflect local community standards.

PHYSICAL FITNESS AND HEALTH

Mr. Porter. What is the status of the physical fitness initiative?

Dr. Macdonald. The physical fitness activity continues to provide staff support and assistance to the President's Council on Physical Fitness and Sports which consists of the Council Chairman and 14 members. The purpose of the Council is to develop and coordinate a national program of physical fitness.

In fulfilling this responsibility, the Council continues to encourage the active involvement of private sector corporations, organizations, and sports associations in promoting improved health for all Americans through participation in regular physical fitness activities. An estimated $[illegible] million is generated annually for physical fitness programs within the private sector.

The Council continues to give high priority to the physical fitness of the youth of our nation through the promotion of several programs specifically for youth such as the Presidential Sports Award, ABC's Fun Fit, and the Navy Corporation Emphasis on Youth Fitness. The results of the latest National Youth Physical Fitness Survey, conducted in Fiscal Year 1985, were released on March [illegible] of this year.

Additionally, the Council is seeking to place greater emphasis on physical fitness for a number of special populations such as working women, the physically handicapped, and older adults. The Council sponsors a variety of projects aimed at these groups such as the National Women's Leadership Conference on Fitness; a national conference on fitness and aging, Physical Exercise Pays (PEP) exercises for seniors, and handicapped wheelchair athletics through participation in such events as the D.C. Games and the Marine Corps Marathon.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

Public Health Service Management

FY 1987 Budget — Page

Appropriation Language 1

Amounts available for obligation 2

Summary of changes 3

Budget Authority by activity 5

Budget Authority by object 7

Significant items in House and Senate Appropriations Committee Reports 8

Authorizing legislation 11

Table of estimates and appropriations 13

Account Summary 14

Justification:

- A. General statement 15
- B. Program Accomplishments 17
- C. Program operations
  - 1. Health Services Research and Health Care Technology Assessment
    - (a) Program operations 19
    - (b) Program support 27
  - 2. Health Statistics
    - (a) Program operations 28
    - (b) Program support 33
  - 3. Adolescent Family Life 35
  - 4. Health Initiatives
    - (a) Smoking and health 38
    - (b) Disease prevention and health promotion 42
    - (c) Physical fitness and sports 46
- D. PHS Management 48
- E. Detail of permanent positions 50
- F. Estimates for consulting services 51
- G. Estimates for related services 53

PUBLIC HEALTH SERVICE MANAGEMENT

For the expenses necessary for the Office of Assistant Secretary for Health and for carrying out [title] *titles III and XX* [1] of the Public Health Service Act, [$91,541,000] *$110,060,000*, together with not to exceed $1,050,000 to be transferred and expended as authorized by section 201(g) of the Social Security Act, from the Federal Hospital Insurance and the Federal Supplementary Medical Insurance Trust Funds referred to therein and, in addition, amounts collected by the National Center for Health Statistics from the sale of data tapes shall be credited to this appropriation and shall remain available until expended. *(Department of Health and Human Services Appropriation Act, 1986; additional authorizing legislation to be proposed for $14,722,000).*

[*Provided further:* That notwithstanding any other provisions of this Act, amounts otherwise provided by this Act for the following accounts and activities are reduced by the following amounts:

OFFICE OF ASSISTANT SECRETARY FOR HEALTH

"Health Statistics", $2,000,000.][2] *(Departments of Labor, Health and Human Services, and Education and Related Agencies Appropriation Act, 1986.)*

Explanation of Language Changes

[1] Title XX of the Public Health Service Act authorizes the Adolescent Family Life program.

[2] Eliminates 1986 language providing for a $2,000,000 reduction in Health Statistics.

Public Health Service Management

Amounts Available for Obligation

	1985	1986	1987
Appropriation:			
Annual..............................	$101,803,000	$104,230,000	$110,060,000
Sequester order..................	---	-4,481,000	---
Subtotal, adjusted appropriation	101,803,000	99,749,000	110,060,000
Comparative transfers from:			
"Program Expenses", FDA - for Standard Level User Charge (SLUC)............	184,000	---	---
"Health Resources and Services" - for SLUC......................	52,000	---	---
"Alcohol, Drug Abuse, and Mental Health" - for SLUC......................	25,000	---	---
"General Departmental Management", DHHS - for SLUC......................	554,000	---	---
Subtotal, adjusted budget authority..........................	102,618,000	99,749,000	110,060,000
Receipts and reimbursements from: Trust Funds for health services research activities................	1,050,000	1,050,000	1,050,000
Pursuant to Health Promotion and Disease Prevention Amendments of 1984, P.L. 98-551 for health services research 1 percent evaluation projects	1,507,000	---	---
Pursuant to Health Services Amendments of 1985, P.L. 99-117 for health services research 1 percent evaluation projects................	---	4,666,000	4,666,000
Pursuant to Health Research Extension Act, P.L. 99-158 for National Research Service Awards.....................	---	1,147,000	1,147,000
Unobligated balance lapsing.........	-558,000	-529,000 [1]	---
Total obligations................	104,617,000 [2]	106,083,000 [2]	116,923,000 [2]

[1] Reflects amount withheld from availability under section 515 of the Treasury, Postal Service, and General Government Appropriations Act authorized under the 1986 Continuing Resolution P.L. 99-190.

[2] Excludes the following amounts for reimbursable activities carried out by this account: FY 1985 - $33,055,000; FY 1986 - $42,811,000; and FY 1987 - $44,932,000.

Public Health Service Management

Summary of Changes

1986 Estimate..	$104,230,000
1986 Sequester Order..	-4,481,000
Total estimated budget authority......................	99,749,000
(Obligations)...	(106,083,000)
1987 Request..	110,060,000
(Obligations)...	(116,923,000)
Net Change...................................	+10,311,000
(Obligations)................................	(+10,840,000)

	1986 Base		Change from Base	
	(FTE)	Budget Authority	(FTE)	Budget Authority
Increases:				
A. Built-in:				
1. Within Grade Increases	---	$37,828,000	---	+$826,000
2. Federal Employee Compensation Fund	---	287,000	---	+30,000
3. Standard Level User Charge	---	3,142,000	---	+31,000
4. FTS and Telecommunications	---	876,000	---	+19,000
Subtotal............			---	+906,000
B. Program:				
1. Research--funding for National Medical Expenditure Survey.	(141)	15,735,000	---	+3,313,000
2. Statistics--to provide funds for the National Health and Nutrition Examination Survey (NHANES) and fund periodic survey requirements.	(486)	44,677,000	---	+5,940,000
3. Adolescent Family Life--net change in dollar levels for grants and contracts.	(17)	14,057,000	---	+652,000
4. Smoking and Health--to provide total annual costs required for smoking prevalence activities.	(17)	3,375,000	---	+139,000
5. Disease Prevention--to provide funds for the National Health Information Clearinghouse (NHIC) to manage the Information Tracking System for data related to the 1990 Health Objectives.	(17)	2,871,000	---	+119,000
6. Physical Fitness--to restore funds for program printing deferred in 1986.	(15)	1,320,000	---	+50,000

7. PHS Management--Restoration of activities deferred from FY 1986 to FY 1987.	(300)	17,714,000	---	+848,000
Subtotal..........			---	+11,061,000
Total, Increases..			---	+11,967,000
Decreases:				
A. Built-in:				
1. PHS Service & Supply Fund.		4,917,000	---	-143,000
2. Management Savings........				-413,000
Subtotal..........			---	-556,000
B. Program:				
1. Research--completion of Hospital Studies and Disease Staging contracts.	(141)	15,735,000	---	-300,000
2. Statistics--completion of Hispanic HANES data collection.	(486)	44,677,000	---	-800,000
Subtotal..........			---	-1,100,000
Total, decreases..			---	-1,656,000
Net Change........			---	+10,311,000

Public Health Service Management
Budget Authority by Activity

	1986 Appropriation Amount	1986 Available after Sequestering		1987 Request	
		FTE	Amount	FTE	Amount
1. Health services research and health care technology assessment					
(a) Program operations............	$15,854,000	111	$15,217,000	111	$18,166,000
(b) Program support...............	1,638,000	30	1,568,000	30	1,663,000
Subtotal.....................	(17,492,000)	141	(16,785,000)	141	(19,829,000)
(c) Appropriation transfer........	-1,050,000	---	-1,050,000	---	-1,050,000
Subtotal.....................	(16,442,000)	141	(15,735,000)	141	(18,779,000)
2. Health statistics					
(a) Program operations............	43,491,000	432	41,621,000	432	46,825,000
(b) Program support...............	3,193,000	54	3,056,000	54	3,193,000
Subtotal.....................	(46,684,000)	486	(44,677,000)	486	(50,018,000)
3. Adolescent Family Life.............	14,689,000	17	14,057,000	17	14,722,000
4. Special health initiatives					
(a) Smoking and health.............	3,526,000	17	3,375,000	17	3,471,000
(b) Disease prevention and health promotion...............	3,000,000	17	2,871,000	17	2,973,000
(c) Physical fitness & sports......	1,379,000	15	1,320,000	15	1,361,000
Subtotal.....................	(7,905,000)	49	(7,566,000)	49	(7,805,000)
5. Public health service management....	18,510,000	300	17,714,000	300	18,736,000
Total.........................	$104,230,000	993	$99,749,000	993	$110,060,000

Budget Authority by Activity

NOTES

Line 1(a). $47,000 will be withheld from obligation pursuant to Section 515 of the Treasury-Postal Services Appropriations Act, authorized under the 1986 Continuing Resolution, P.L. 99-190.

Line 2(a). $113,000 will be withheld from obligation pursuant to Section 515 of the Treasury-Postal Services Appropriations Act, authorized under the 1986 Continuing Resolution, P.L. 99-190.

Line 3. $79,000 will be withheld from obligation pursuant to Section 515 of the Treasury-Postal Services Appropriations Act, authorized under the 1986 Continuing Resolution, P.L. 99-190.

Line 4(a). $174,000 will be withheld from obligation pursuant to Section 515 of the Treasury-Postal Services Appropriations Act, authorized under the 1986 Continuing Resolution, P.L. 99-190.

Line 4(b). $100,000 will be withheld from obligation pursuant to Section 515 of the Treasury-Postal Services Appropriations Act, authorized under the 1986 Continuing Resolution, P.L. 99-190.

Line 4(c). $16,000 will be withheld from obligation pursuant to Section 515 of the Treasury-Postal Services Appropriations Act, authorized under the 1986 Continuing Resolution, P.L. 99-190.

Public Health Service Management

Budget Authority by Object 1/

	1985 Actual 4/	1986 2/ 3/ Current Estimate	1987 2/ 3/ Estimate
Total number of full-time permanent positions..............	913	926	926
Total compensable workyears:			
Full-time equivalent employment..	1,053	1,012	1,012
Full-time equivalent of overtime and holiday hours...............	16	16	16
Average GS Grade..................	10.53	10.53	10.57
Average GS Salary..................	$34,600	$34,700	$34,800
Average ES Salary..................	$68,300	$68,300	$68,300
Personnel compensation:			
Full-time permanent.................	$34,660,000	$34,065,000	$35,061,000
Other than full-time...............	3,125,000	3,355,000	3,476,000
Other personnel compensation	620,000	725,000	857,000
Special personnel services payments	169,000	148,000	148,000
Subtotal, personnel compensation....	38,567,000	38,293,000	39,542,000
Personnel benefits..................	4,621,000	4,727,000	5,082,000
Benefits for former personnel.......	42,000	25,000	---
Travel and transportation of persons	1,263,000	1,470,000	1,863,000
Transportation of things............	89,000	99,000	111,000
Standard level user charge..........	3,120,000	3,142,000	3,173,000
Rent payments to others.............	173,000	178,000	303,000
Communications, utilities & misc charges..............................	4,104,000	4,293,000	4,483,000
Printing and reproduction...........	1,034,000	1,050,000	1,132,000
Other services......................	17,020,000	15,132,000	16,562,000
Project contracts...................	10,054,000	13,394,000	19,385,000
Supplies and materials..............	450,000	580,000	623,000
Equipment...........................	1,243,000	1,419,000	1,462,000
Grants, subsidies and contributions......................	22,160,000	22,002,000	21,282,000
Unobligated balance lapsing.........		-528,000 5/	
Total obligations by object......	104,617,000	106,087,000 6/	116,923,000

1/ Includes transfer from the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds amounts of $1,050,000 for FY 1985, FY 1986 and FY 1987.

2/ Includes funds authorized under the Health Services Amendments of 1985, P.L. 99-117: FY 1986, $4,444,000 and FY 1987 estimate of $4,444,000.

3/ Includes funds authorized under the Health Research Extension Act, P.L. 99-158: FY 1986, $1,147,000 and FY 1987 estimate of $1,147,000.

4/ Reflects funds authorized under the Health Promotion and Disease Prevention Amendments of 1984, P.L. 98-551: FY 1985, $1,307,000.

5/ Reflects amount withheld from availability under Section 515 of the Treasury, Postal Service, and General Government Appropriations Act, authorized under the 1986 Continuing Resolution, P.L. 99-190.

6/ Reflects reduction of $4,481,000 pursuant to the Balanced Budget and Emergency Deficit Control Act of 1985, P.L. 99-177.

Significant Items in House and Senate
Appropriations Committee Reports

Item	Action Taken or to be Taken
FY 1986 House Report No. 99-289 Coordination of AIDS Effort - The Committee believes it is essential that a permanent coordinator be appointed to take charge of all aspects of the current and future efforts against the disease.... The Committee urges the Secretary of Health and Human Services to appoint a permanent coordinator over the AIDS effort, who shall exercise oversight over the funds appropriated for the national effort against AIDS, in accordance with a coordinated plan that will be devised and submitted to the Committee.	The FY 1987 budget request establishes a new appropriation within the Office of the Assistant Secretary for Health which will include a consolidated funding request for AIDS-related activities. In addition, a permanent coordinator and support staff will be established to exercise oversight over these funds. In FY 1986 a temporary coordinator has been appointed by the Acting Assistant Secretary for Health. This has been done on a temporary basis in order to permit the new Assistant Secretary for Health to make the permanent appointment. An AIDS coordination plan was submitted to the Committee on November 8, 1985.
FY 1986 Senate Report No. 99-151 International Health Activities - ...The Committee encourages HHS to continue to provide support for such activities and to develop a comprehensive report for the Congress on its international activities during this fiscal year.	A report on the international health activities of the Public Health Service is being prepared and will be sent to the Senate Appropriations Committee.
Biofeedback Technology - The Committee is interested in receiving information from the Department regarding the clinical efficiency of biofeedback technology. ...The Committee would also like to be informed of the extent to which various agencies within HHS have funded research projects on this clinical modality.	The National Center for Health Services Research and Health Care Technology Assessment (NCHSR/HCTA) is preparing a report on the activities of various agencies within HHS on biofeedback technology as a treatment for incontinence. It is anticipated that the report will be sent to the Senate Appropriations Committee prior to the fiscal year 1987 budget hearings.

Evaluation Funds - ...The Committee directs that the [National] Center [for Health Services Research and Health Care Technology Assessment] be allocated the full 1½ percent of evaluation funds available to the Office of the Secretary.	The National Center for Health Services Research and Health Care Technology Assessment will be allocated ½ percent of the total evaluation funds available.
Agency Coordination of Research - The Committee recognizes that analysis and research on the cost and efficiency of health care and health service delivery occur in at least three separate places within the Federal Government: The National Center for Health Services Research and Technology Assessment; Health Care Financing Administration [HCFA]; and the Prospective Payment Assessment Commission [ProPAC]. The Committee would like to receive information concerning the amount of coordination that exists between these three agencies at present and what plans exist, if any, for the future. The Committee directs the heads of these agencies to submit a brief report addressing these concerns to this Committee before the fiscal year 1987 budget hearings.	Staff of the National Center for Health Services Research and Health Care Technology Assessment are preparing a report which describes the coordination that exists between the NCHSR/HCTA, the Health Care Financing Administration (HCFA), and the Prospective Payment Assessment Commission (ProPAC). The report will be sent to the Senate Committee on Appropriations prior to the fiscal year 1987 budget hearings.
Quality of National Health Data - The Committee... directs the Director of the National Center for Health Statistics to submit an indepth report assessing the impact of funding and personnel limitations on the data system of NCHS and the resulting impact on the utility of this data. In addition and more specifically, the report should address: (1) the present and future quality of vital statistics data provided NCHS by the States, and the ability of the States and NCHS to respond to priority data needs; (2) what the impact of reduced sample sizes in NCHS	The National Center for Health Statistics is preparing a report which assesses the impact of funding and personnel limitations on the NCHS data system and the quality of data produced as a result of those limitations. It is anticipated that the report will be sent to the Senate Appropriations Committee prior to the fiscal year 1987 budget hearings.

surveys will be; (3) how the NOS keeps pace with other agencies and the private sector in adopting modern survey technologies, and what would it cost to bring the NOS technological capabilities to state-of-the-art status; (4) an evaluation of NOS's current organizational setting and how that may be improved; and (5) to what extent can resources that may be available from other programs and/or agencies be used to automate essential data systems in times of limited fiscal resources.

The Committee expects that this report will be available before the fiscal year 1987 budget hearings.

Authorizing Legislation

	1986 Amount Authorized	1986 Current Estimate		1987 Amount Authorized	1987 Budget Request	
Public Health Service Management						
1. Health services research/NCHS						
(a) Program operations: Public Health Service Act (PHSA) Sections 301 and 304	[illegible]	[illegible]		[illegible]	[illegible]	
(b) Program support: PHSA Section 301	Indefinite	[illegible]		Indefinite	[illegible]	
(c) Appropriation transfer: Social Security Act Section [illegible]	Indefinite	[illegible]	[illegible]	Indefinite	[illegible]	[illegible]
2. Health statistics						
(a) Program operations: PHSA Sections 304 and 306	[illegible]	[illegible]		[illegible]	[illegible]	
(b) Program support: PHSA Section 301	Indefinite	[illegible]		Indefinite	[illegible]	
3. Adolescent family life: PHSA Section 2010	[illegible]	[illegible]		[illegible]	[illegible]	
4. Special health initiatives						
(a) Smoking & health: PHSA Section 301	Indefinite	[illegible]		Indefinite	[illegible]	
(b) Disease prevention and health promotion: PHSA Section 301	Indefinite	[illegible]		Indefinite	[illegible]	
(c) Physical fitness and sports: PHSA Section 301	Indefinite	[illegible]		Indefinite	[illegible]	
5. Public health service management: PHSA Section 301	Indefinite	[illegible]		Indefinite	[illegible]	

BEST COPY AVAILABLE

	1986 Amount Authorized	1986 Current Estimate	1987 Amount Authorized	1987 Budget Request
Unfunded Authorizations				
Emergency Response Fund PHSA Section 319	30,000,000	---	30,000,000	---
Total appropriation		$99,749,000 3/		$110,060,000
Total Appropriation against definite authorizations	$101,750,000	$55,788,000	$106,750,000	$63,941,000

1/ The appropriation transfer of $1,050,000 is from the Federal Hospital Insurance and the Federal Supplementary Medical Insurance Trust Funds as authorized by Section 201(g) of the Social Security Act. This transfer, shown as a non-add item does not increase NCHSR/HCTA budget authority.

2/ Authorization for PHSA Section 2010 funds expired September 30, 1985. Current year funds are authorized under the Fiscal Year 1986 Continuing Resolution, P.L. 99-190. Extension legislation has been proposed.

3/ Reflects a reduction of $4,481,000 pursuant to the Balanced Budget and Emergency Deficit Control Act of 1985, P.L. 99-177. In addition, $529,000 will be withheld from obligation pursuant to Section 515 of the Treasury, Postal Service and General Government Appropriations Act as authorized under the 1986 Continuing Resolution, P.L. 99-190.

Public Health Service Management

Table of Estimates and Appropriations

Year	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation 1/
1977	$79,462,000	$89,298,000	$87,118,000	$87,198,000
1978	84,952,000	96,552,000	98,952,000	101,421,000
1979	130,418,000	105,213,000	109,112,000	104,927,000
1980	130,005,000	133,511,000	145,028,000	113,476,000
1981	150,614,000	160,644,000	150,644,000	152,553,000
1982	184,800,000	146,618,000	125,520,000	129,608,000
1983	105,778,000	96,016,000	92,053,000	94,034,000
1984	123,847,000	107,887,000	105,587,000	106,487,000
1985	113,128,000	102,618,000	102,618,000	102,618,000
1986	106,809,000	88,671,000 2/	94,136,000 2/	104,230,000
1986 Sequester	-4,481,000			
1987	110,060,000			

1/ Reflects enacted supplementals, rescissions and reappropriations.

2/ House and Senate deferred action on request of $14,729,000 for Adolescent Family Life program.

Public Health Service Management

Account Summary

	1985	1986	1987
1. Health services research and health care technology assessment:			
a. Program operations.....	$15,916,000	$15,217,000	$18,166,000
b. Program support........	1,620,000	1,568,000	1,663,000
c. Appropriation transfer.	(1,050,000)	(1,050,000)	(1,050,000)
Subtotal.........	16,486,000	15,735,000	18,779,000
2. Health statistics:			
a. Program operations.....	39,338,000	41,621,000	46,825,000
b. Program support........	3,472,000	3,056,000	3,193,000
Subtotal.........	42,810,000	44,677,000	50,018,000
3. Adolescent family life.....	14,890,000	14,057,000	14,722,000
4. Special health initiatives:			
a. Smoking and health.....	3,538,000	3,375,000	3,471,000
b. Disease prevention and health promotion......	3,645,000	2,871,000	2,973,000
c. Physical fitness and sports................	1,364,000	1,320,000	1,361,000
Subtotal.........	8,547,000	7,566,000	7,805,000
5. Public health service mgmt.	19,885,000	17,714,000	18,736,000
TOTAL............	102,618,000	99,749,000 1/	110,060,000

1/ Reflects a reduction of $4,481,000 pursuant to the Balanced Budget and Emergency Deficit Control Act of 1985, P.L. 99-177. In addition, $529,000 will be withheld from obligation pursuant to Section 515 of the Treasury, Postal Service and General Government Appropriations Act as authorized under the 1986 Continuing Resolution, P.L. 99-190.

General Statement

The Public Health Service Management appropriation supports the two major responsibilities of the Office of the Assistant Secretary for Health (OASH). The first of these functions is the leadership and direction of the activities of the Public Health Service (PHS) agencies. Plans and strategies for accomplishing National health goals are formulated in cooperation with the agencies for implementation throughout PHS. The second major function is the operation of several high priority programs within OASH that have a variety of missions and responsibilities.

In FY 1987 the Office of the Assistant Secretary for Health will continue to assist the agencies in meeting the primary goal of the Public Health Service which is, in concert with the private sector, to help protect and improve the health of the American people. Guidance is provided to the agencies in their efforts to help assure access to reasonable health care at reasonable cost, and to help prevent illness and disease. PHS activities include research and development, manpower development and training, improving access to health care and preventive health care services, improving the methods and resources required to deliver health care, providing health care to Indian and Alaskan Natives; protecting the public from unsafe foods, drugs and medical devices, and providing Federal administration of the Block Grants to States for Health.

In addition to the overall management responsibility for PHS, OASH directly manages several high priority programs. Two national centers, Health Services Research/Health Care Technology Assessment (NCHSR/HCTA) and Health Statistics, have unique responsibilities. NCHSR/HCTA is the primary source of Federal support for research on problems related to the quality and delivery of health services. The Center seeks to create new knowledge and a better understanding of the processes by which health care services are made available, and how they may be provided more efficiently, more effectively, and at lower cost. The National Center for Health Statistics is responsible for the collection, maintenance, analysis and dissemination of statistics on health; illness and disability; the impact of illness and disability on the economy; the effects of environmental, social and other health hazards; the utilization of health care services and resources; health care costs and financing; family formation, growth and dissolution; and vital events.

One of the major priorities of the PHS is prevention of disease and promotion of good health practices. The provision of preventive health services, the protection of our environment, and the promotion and adoption of healthy lifestyles represent important ways for individuals and society to reduce major risk factors for disease and early death, and substantially improve the health of Americans. Three OASH programs -- Smoking and Health, Disease Prevention and Health Promotion, and Physical Fitness -- educate the public about occupational, societal, environmental and behavioral factors which affect health. Efforts are focused on encouraging beneficial lifestyle changes through a variety of programs which include media campaigns, clearinghouses, and workshops.

Another high priority program managed within OASH is the Adolescent Family Life program which seeks to find effective means of addressing the problems associated with adolescent premarital sexual activity, pregnancy and childrearing, giving particular attention to the role of the family in these matters. The program supports and evaluates model demonstration projects to identify effective service delivery programs for use by states and local communities and by supporting research, evaluation, and dissemination activities.

The budget request assumes enactment of pending legislation to extend section 2010 of the PHS Act.

Program Accomplishments

The accomplishments of the Office of the Assistant Secretary for Health (OASH) are related to its twofold mission of providing leadership and direction to the Public Health Service (PHS) agencies and operating several high priority programs. PHS is able to accomplish specific objectives through the efforts of the individual agencies. These accomplishments are addressed in the separate agency budget justifications. Under the leadership of the Assistant Secretary for Health, PHS as an entity, can accomplish overall objectives because of the successful interaction of the components when faced with major issues and challenges. This interaction and collaboration is facilitated under the direction of the Assistant Secretary for Health.

For example, during 1985 the PHS agencies continued to respond to the serious health hazards posed by AIDS. The public information campaign, including a National AIDS toll-free hotline, was maintained and research efforts involved the National Institutes of Health (NIH), the Centers for Disease Control (CDC), the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) and Food and Drug Administration (FDA). Working with public and private organizations, PHS developed and issued guidelines to assist State and local officials in making decisions on how best to protect the public health. Another continuing collective effort is a three-year study of Reye's Syndrome to establish a surveillance network which will identify cases and susceptible subgroups. This effort involves FDA, CDC and NIH. As the U.S. population ages, the number of people affected by Alzheimer's disease is rising. ADAMHA and NIH are actively involved in research activities and a task force is coordinating intensive research and working to translate research findings into practical means for improving the quality of life for older Americans. These are a few examples of the PHS components working together under the direction of the Assistant Secretary for Health to accomplish a health mission.

Prevention continues to be a major health initiative of the Public Health Service. Measurable health objectives for the Nation, to be achieved by 1990, form the framework for PHS efforts in support of this basic policy. In 1985, a midcourse review of the 1990 health objectives was conducted by the Disease Prevention and Health Promotion activity in OASH. This review found that approximately 50 percent of the 227 objectives have either been achieved already or are on track to being achieved by 1990. The remaining objectives require renewed attention and/or better surveillance. Also in 1985, Prevention '84/'85, an examination of the nature and scope of Federal activities designed to facilitate accomplishment of our national health objectives, was issued.

Other programs funded in OASH contribute significantly to the disease prevention and health promotion effort. Data collected by the National Center for Health Statistics on such topics as infant mortality, high blood pressure and immunization will be critical to the monitoring of the 1990 objectives. Research to improve the delivery of preventive medicine continues to be an important component of the research activities of the National Center for Health Services Research and Health Care Technology Assessment. The Adolescent Family Life program funded 79 demonstration projects offering a variety of care and prevention services and contributing to improved maternal and neonatal health outcomes. Care projects have been especially successful in reducing low birth weight, low gestational age and medical complications associated with adolescent pregnancy. Care programs have consistently indicated a lower incidence of repeat pregnancies among their clients when compared to national vital statistics. Results from one research project show that the better the communication between parents and their children, the more likely the child will delay the onset of sexual activity. Therefore, a major emphasis and success of prevention projects has been to increase teen-parent communication. Prevention projects have also been instrumental in developing innovative ways to improve teen self-esteem, knowledge of sexuality and decision making skills.

During 1985, the Surgeon General's report on The Health Consequences of Smoking: Cancer and Chronic Lung Disease in the Workplace, prepared by the Office on Smoking and Health was released. The report examines the evidence available on the role played by cigarette smoking and occupational exposures in the development of cancer and chronic lung disease. Cancer and chronic lung disease are major causes of death in the United States, accounting for well over 25 percent of all deaths annually. The report also presents detailed findings with regard to differences in smoking prevalence between blue-collar workers and white-collar workers. The 1986 Surgeon General's report will focus on passive smoking.

Exercise and physical fitness is one of the 15 priority areas for improving the health of the American people. Lead responsibility for this objective rests with the President's Council on Physical Fitness and Sports. The Council staff continued a highly successful program of encouraging physical fitness for all Americans.

The National Center for Health Statistics completed data collection for the Hispanic Health and Nutrition Examination Survey in FY 1985. Analysis of this special data and issuance of reports is ongoing. Planning and development for the next cycle of the National Health and Nutrition Examination Survey was initiated in FY 1986 as well as for Cycle IV of the National Survey of Family Growth. These surveys as well as all the other surveys conducted by NCHS continue to provide a basic source of data vital to the public and the private sector in the health arena to assess the health status of the population as well as changes in availability of, access to, and use of health care resources.

The National Center for Health Services Research and Health Care Technology Assessment seeks to create new knowledge and better understanding of the processes by which services are made available, and how the services may be provided more efficiently, more effectively, and at lower costs. In 1985, progress was made in the planning for the 1987 National Medical Expenditures Survey. This survey will produce national estimates of health insurance coverage and the use of and expenditures for health care services.

In summary the programs in the Office of the Assistant Secretary for Health and of the Public Health Service, in general, continue to make significant accomplishments toward the goal of helping to protect and improve the health of the American people.

Public Health Service Management

1. Health services research and health care technology assessment:
   (a) Program operations (b) Program support
   (Section 301 and 308 of the Public Health Service Act)

1987 Authorization: $24,750,000

Budget Authority:

	1986 Appropriation	1986 Available after Sequestering	1987	Increase or Decrease
Program Operations	$14,604,000	$14,167,000	$17,116,000	+$2,949,000
Program Support	1,638,000	1,568,000	1,663,000	+95,000
TOTAL	$16,442,000 1/	$15,735,000 1/	$18,779,000	+$3,044,000
Obligations	(23,817,000) 2/	(22,598,000) 3/	(25,642,000) 3/	(+3,044,000)
FTEs		141	141	---

1/ $47,000 will be withheld from obligations pursuant to Section 515 of the Treasury, Postal Service, and General Government Appropriations Act, authorized under the 1986 Continuing Resolution, P.L. 99-190.

2/ Includes transfer of $1,050,000 from the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, $5,126,000 from funds authorized under section 5(h) of P.L. 98-551, and $1,199,000 for National Research Service Awards authorized under P.L. 99-158.

3/ Includes transfer of $1,050,000 from the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, $4,666,000 from funds authorized under section 5(h) of P.L. 98-551, and $1,147,000 for National Research Service Awards authorized by P.L. 99-158.

Purpose and Method of Operation

The National Center for Health Services Research and Health Care Technology Assessment (NCHSR) seeks to create new knowledge and better understanding of the processes by which health services are made available, and how they may be provided more efficiently, more effectively, and at lower cost.

NCHSR responds to the need for better data and information, new techniques, and innovative methods for improving health care delivery. NCHSR programs evaluate health services, assess technologies, and improve access to new scientific and technical information for research users. NCHSR's research is targeted to the needs of health care policymakers, including executive and legislative officials at Federal, State and local levels; those who operate hospitals and other health care institutions; and individuals who are responsible for health care expenditures.

Public Health Service Management

1. Health services research and health care technology assessment:
(a) Program operations (b) Program support

The NCHSR extramural research program provides support for investigator-initiated projects in health services research conducted at universities; nonprofit organizations and institutions, such as teaching hospitals; and by industry.

Extramural research activities

NCHSR's extramural research program is directed toward:

(1) Health promotion and disease prevention: health status measurement, organization and provider studies, analysis of public and private program interventions, and methods to increase consumer knowledge and change health attitudes and behavior.

(2) Technology assessment: studies of the safety, efficacy, effectiveness, and cost effectiveness of specific technologies; development of new methods for evaluating medical technologies; and diffusion of medical technology.

(3) The role of market forces in the delivery of health care: market and industry structure, expenditure studies, strategies to enhance cost consciousness, and productivity studies.

(4) Primary care: development and testing of better designs, measure, and analytic techniques to improve primary care research; evaluation and surveillance techniques to assess the quality of care and the effectiveness of health promotion and disease prevention efforts; studies of the medical decisionmaking process; and systematic evaluations of the effectiveness and costs of clinical care.

(5) State and local health problems: improving data and methods for projecting the demand for service and related supply requirements, and forecasting health expenditures; studies to develop and evaluate decision models for allocating health care resources at various jurisdictional levels and among various programs in a cost-effective manner; and techniques to assess and project the impact of changes in health expenditures.

Investigator-initiated research projects are reviewed for scientific merit by non-Federal peer review panels, and are selected for funding on the basis of their scientific merit and their potential for improving the cost-effectiveness and quality of health services. Dissertation research grants are available as part of an effort to stimulate the development of additional health services research skills.

Public Health Service Management

1. Health services research and health care technology assessment:
   (a) Program operations (b) Program support

Intramural research activities

The most significant effort in this area is the FY 1987 National Medical Expenditure Survey (NMES). This survey will provide the Executive Branch and the Congress with national estimates of the use of and expenditures for health care services and health insurance coverage. These estimates cover both the civilian noninstitutionalized population and the population in nursing homes, psychiatric hospitals, and facilities for the mentally retarded. Support for NMES will be provided by HCFA, NIH and NIMH, as well as NCHSR. The NMES sample will include approximately 13,000 households. Groups of particular policy interest, such as blacks, Hispanics, the poor and near poor, and the elderly, will be oversampled. The NMES household survey will be a year long panel, collecting measures of health status, use of health care services, expenditures and source of payment, insurance coverage, employment, income and assets, and demographic information. Household data will be supplemented by surveys of medical and health insurance providers and by data from Medicare administrative files. An important feature of NMES will be an institutional population component which will survey about 10,000 persons in nursing homes, facilities for the mentally retarded, and psychiatric hospitals. NMES succeeds a series of National Medical Expenditure Surveys, most notably the 1980 National Medical Care Utilization and Expenditure Survey (NMCUES) and the 1977 National Medical Care Expenditure Survey (NMCES). The value of having such comprehensive population-based data sets has been demonstrated on numerous occasions. These data made it possible to provide frequent and substantial consultative assistance to agencies such as OMB, CBO, HCFA and others. NMES will make it possible to assess the impact on the structure of services and expenditure trends of such innovations as prospective payment under Medicare, the redesign of state Medicaid programs, changes in private health insurance benefits, and the growth of HMO and other provider arrangements.

The data base developed for the Hospital Cost and Utilization Project (HCUP) includes information on all discharges from a sample of almost 400 acute care hospitals, as well as data on the finances of the hospitals, the characteristics of the physician staff, and the sociodemographic and medical characteristics of the immediate hospital environment. Assembled between 1978 and 1980, the data covered the years 1970 to 1977. NCHSR is now in the process of acquiring data for the same hospitals for the period 1980 to 1984. Both HCFA and the Public Health Service believe that this data base will provide a unique opportunity to evaluate the impact of the Medicare prospective payment system. The data are also being used to analyze the factors which influence the use of technology in hospitals, the purchase of new capital equipment, changes in the financial status of acute care institutions, and the impact of new competitive arrangements in the hospital sector. All data for this project are being acquired from secondary sources.

Public Health Service Management

1. Health services research and health care technology assessment: (a) Program operations (b) Program support

---

The development of these two data bases will represent a major commitment in FY 1987. The contract for NMES was awarded in January 1986 and the survey itself will be fielded beginning in January 1987. The household component of the survey will be completed by April 1988. Follow-back surveys to a sample of providers, employers, and insurance companies will be completed during calendar year 1988. The first data from the household survey will be available for analysis in the Spring of 1988. Data for the Hospital Cost and Utilization Project for the period 1980 to 1984 were available for analysis in January 1986. Data for the subsequent years will be added to the set as it is obtained and will be immediately available for various policy studies.

Program Operations

	1986 Appropriation 1/	1986 Available after Sequestering 1/	1987	Increase or Decrease
	$14,804,000	$14,167,000	$17,116,000	+$2,949,000
Obligations	(22,179,000) 2/	(21,030,000) 2/	(23,979,000) 3/	(+2,949,000)
FTEs		103	103	---

1/ $67,000 will be withheld from obligations pursuant to Section 515 of the Treasury-Postal Service, and General Government Appropriations Act, authorized under the 1986 Continuing Resolution, P.L. 99-190.

2/ Includes transfer of $1,690,000 from the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, $5,126,000 from funds authorized under section 513 of P.L. 98-551, and $1,190,000 for National Research Service Awards authorized by P.L. 99-158.

3/ Includes transfer of $1,690,000 from the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, $4,006,000 from funds authorized under section 513 of P.L. 98-551, and $1,167,000 for National Research Service Awards authorized by P.L. 99-158.

1987 Budget Proposal

The FY 1987 request for NCHSR Program Operations is $17,116,000 and 103 FTE's. This represents an increase of $2,949,000 over the FY 1986 level. These additional funds have been allocated to support the National Medical Expenditure Survey which is being conducted for the NCHSR Division of Intramural Research. Added to the Budget Authority requested are transfers totaling $6,863,000. These are: $1,690,000 from the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds to support

Public Health Service Management

1. Health services research and health care technology assessment:
   (a) Program operations (b) Program support

---

analyses of Medicare reimbursement issues, relevant research activities and the dissemination of information; $1,167,000 for National Research Service Awards in health services research; and $4,666,000 from funds for DHHS-wide evaluation activities. Specifically, this amount will be used to evaluate health services and health care technologies.

The request will provide funds for new and continuing extramural and intramural studies in priority research areas and dissemination activities in addition to the Center's priority for building the knowledge base in health services research. In 1987 priority will be given to investigator-initiated applications that address variations in medical care technology assessment, role of market forces in health care delivery and health promotion and disease prevention.

Variations in Medical Care - NCHSR funded the ground-breaking research on the important issue of variations in medical practice and over the years the knowledge base on this issue has grown through NCHSR support. Analyses of small area data and large data sets have consistently indicated that patient need is not the sole force driving how resources are used in health care. Health services research has shown that variation in utilization reflects a complex interaction of clinical, social, environmental, economic and psychological factors which characterize the relationship between patient and provider. Studies have consistently demonstrated that differences in medical decision making are often the result of how physicians are trained and of financial incentives in the health care delivery system. Continued empirical analyses of the system are necessary to highlight those medical procedures which could be performed more efficiently or those diseases which could be treated more effectively.

The following are examples of the kinds of research that NCHSR intends to pursue to obtain a better understanding of variations in the use of medical resources and related outcomes:

- Expanded quality assessment efforts such as studies linking the process of care with outcomes and health status, as well as better ways to measure the effectiveness of the cognitive elements of medical care such as patient-provider communication, and to explore the area of patient and societal preferences or utilities.
- Sources of data to examine the course of episodes of illnesses over time, including measures of health outcomes which can be obtained unobtrusively.
- Population-based data for comparative studies of variations in use, particularly with regard to disadvantaged groups, and data which can be used to observe changes in variations over time.

16

Public Health Service Management

1. Health services research and health care technology assessment: (a) Program operations (b) Program support

---

- Research designs such as cohort or case-control studies which can be carried out in addition to randomized controlled clinical trials in promoting consensus about treatment effectiveness.

Technology Assessment

NCHSR would be able to fund a number of studies in technology assessment which have the potential for saving lives as well as dollars:

- Previous NCHSR research has demonstrated the effectiveness in saving lives of providing cardiopulmonary resuscitation (CPR) instruction over the telephone. The proposed study would test the effectiveness of a new type of telephone CPR instruction.

- Another study proposes to demonstrate that a computerized infectious disease monitoring system can be used to decrease the inappropriate use of antibiotics, and perform surveillance of hospital-acquired infections more effectively than traditional surveillance systems.

- The goal of a third proposed study is to reduce the inappropriate use of blood products, a problem with substantial cost implications.

Role of Market Forces in Health Care Delivery – NCHSR would also fund important studies on the role of market forces in health care delivery and other financing issues. For example:

- One study proposes to analyze the effects of a competitive health market on inpatient use of resources in the Twin Cities area, a market area in which forty percent of the population belongs to a health maintenance organization (HMO).

- A second study proposes to determine what factors differentiate consistently high and low users of medical care among the elderly, examining such factors as differences in types of services and procedures; relative values and costs of procedures; reasons for seeking care; differences in health habits and health status; socioeconomic differences and place of service.

- Another study proposes to estimate the extent of adverse selection in employer-provided multiple-option group health insurance. Adverse selection (the tendency of individuals who anticipate higher levels of utilization of health services to select more comprehensive health insurance coverage) is seen by theoreticians of competition in health care as a major potential obstacle to the creation of a truly competitive health care marketplace.

Public Health Service Management

1. Health services research and health care technology assessment:
 (a) Program operations (b) Program support

Health Promotion and Disease Prevention

Another important focus of NCHSR's extramural research program is health promotion and disease prevention (HPDP). Two studies could contribute to the further development of the HPDP knowledge base:

- One study would examine factors related to use of prenatal care among immigrant women, a population at high risk of adverse pregnancy outcomes.

- Another study seeks to determine the economic costs associated with three unhealthy habits -- smoking, drinking, and lack of exercise. A paradoxical relationship may exist between poor health habits and utilization: there may be a short-term increase in health care costs associated with some unhealthy habits which outweigh the discounted long-term effects of increased costs.

Technology Assessment Activities

The Office of Health Technology Assessment conducts evaluations of the safety and clinical effectiveness of medical technologies in response to requests from the Health Care Financing Administration (HCFA). The medical and scientific information provided assists HCFA in the policy formulation and decisionmaking processes involving issues related to Medicare coverage.

NCHSR Program Operations by Activity

	1985 Actual		1986 Available after Sequestering		1987	
	No.	Amount	No.	Amount	No.	Amount
Research Grants and Contracts:						
New	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Continuations	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Total	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Direct Operations	--	[illegible]	--	[illegible]	--	[illegible]
Total Research Obligations	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
NRSA Training Grants	---	---	[illegible]	[illegible]	[illegible]	[illegible]

Public Health Service Management

1. Health services research and health care technology assessment:
   (a) Program operations (b) Program support

In FY 1987, this activity is requesting $17,116,000 and 103 FTEs, a net increase of $2,949,000 over the FY 1986 amount after sequestering. The FY 1987 request includes program increases of $3.225,000 and the following built-in costs:

Built-in costs:

Within-grade increases	+92,000
PHS Service and Supply Fund	-17,000
Federal Employee Compensation Fund	+4,000
Federal telecommunications system	+3,000
Management Savings	-58,000
Non-recurring costs	-300,000
Net Change	-$276,000

Public Health Service Management

1. Health services research and health care technology assessment:
(a) Program operations (b) Program support

Program support

	1986 Appropriation	1986 Available after Sequestering	1987	Increase or Decrease
	$1,638,000	$1,568,000	$1,663,000	+$95,000
Obligations	(1,638,000)	(1,568,000)	(1,663,000)	(+95,000)
FTEs		38	38	---

Purpose and Method of Operations

The program support activity provides for the planning, coordination, and management of the various health services research programs. Included are the setting and administering of policies and procedures, and the direction and administration of a research program consisting of extramural and intramural research components. Funding is also provided for a variety of administrative management functions.

1987 Budget Proposal

In FY 1987, this activity is requesting $1,663,000 and 38 FTEs, a net increase of $95,000 over the FY 1986 amount after sequestering. The FY 1987 request includes the restoration of equipment funding deferred in FY 1986. The following built-in costs are also included:

Built-in costs:	
Within-grade increases........................	+9,000
PHS Service and Supply Fund..................	-3,000
Federal telecommunications system............	+1,000
Net change................................	+$7,000

BEST COPY AVAILABLE

2. Health Statistics
(Sections 301 and 308 of the Public Health Service Act)

Budget Authority:

	1986 Appropriation	1986 Available After Sequestering	1987	Increase or Decrease
Program Operations...	$43,491,000	$41,621,000	$46,825,000	+$5,204,000
FTE		432	432	0
Program Support......	3,193,000	3,056,000	3,193,000	+137,000
FTE		54	54	0
Total.........	46,684,000 1/	44,677,000 1/	50,018,000	+5,341,000
FTE		486	486	0

1/ $113,000 will be withheld from obligation pursuant to Section 515 of the Treasury, Postal Service, and General Government Appropriations Act, authorized under the 1986 Continuing Resolution, P.L. 99-190.

The National Center for Health Statistics (NCHS) is the Federal Government's principal health statistics agency. NCHS data systems address the full spectrum of concerns in the health field from birth to death, including overall health status, life style and exposure to unhealthful influences, the onset and diagnosis of illness and disability, and the use of health care and rehabilitation services.

1987 Authorization: $52,000,000

Budget Authority:

	1986 Appropriation	1986 Available After Sequestering	1987	Increase or Decrease
Program Operations...	$43,491,000	$41,621,000	$46,825,000	+$5,204,000
FTE		432	432	0

Purpose and Method of Operation

Over its 25 year history, NCHS has developed and adapted survey mechanisms to address critical policy and research issues as they have evolved, and now maintains over a dozen data systems involving personal interviews; physical examinations and laboratory testing; review of hospital, nursing home, and physician records; and other survey methods.

NCHS is the source of a wide range of critical information regularly used by policymakers in the Congress and Administration, medical researchers, and others in the health community. This information includes:

2. Health Statistics

- infant mortality and information on low birth weight, maternal smoking, and other factors in the pregnancy that may cause infant death;
- life expectancy, causes of death, and other information based on vital records;
- the health implications of an aging population and consequent impacts on the health care system;
- the health of minorities and their use of the health care system;
- risk factors associated with cancer, heart disease, and other illnesses;
- health promotion and disease prevention, including personal health habits and characteristics and their impact on health;
- changes in medical practice and the utilization of health services; and
- the nutritional status of the population and its impact on health.

HEALTH STATISTICS SURVEYS AND ACTIVITIES

	1985 Actual	1986 Available After Sequestering	1987
On-going Basic Data Collection	$13,147,000	$12,297,000	$ 14,645,000
Survey Programs			
Household Interview Statistics...	8,380,000	8,395,000	8,499,000
Health Examination Statistics..	5,983,000	7,119,000	9,704,000
Health Care Resources and Utilization Statistics.............	3,968,000	5,017,000	5,105,000
Other Program-Activities			
Analysis, Epidemiology and Environmental Health Statistics; Data Dissemination Service/Automation; Research and Methodology and Survey Design Integration......	7,759,000	8,793,000	8,872,000
TOTAL..............	$39,237,000	$41,621,000	$46,825,000

NOTE: Some surveys are funded in part through reimbursable agreements with other agencies. Costs shown represent NCHS costs only.

Public Health Service Management

2. Health Statistics

The estimates of survey costs displayed reflect direct and indirect costs as well as a proportionate share of overhead costs related to rent, utilities, communications, etc. Since overhead costs are relatively fixed, the elimination of any survey would result in increased costs of all other surveys.

The surveys and data systems of NCHS fall into two categories: 1) those that are operated on an annual, or continuous basis; and 2) those that are conducted on a regular, periodic basis at intervals of up to 6 years, in accordance with an overall periodicity plan for surveys. For the first category, the budget required remains relatively stable from year to year. For periodic surveys, however, the required budget fluctuates considerably depending on the particular phase of those surveys (e.g., data collection, analysis, etc.) during the budget year. As a result, the budget request may reflect changes from year to year without reflecting a change in the NCHS program.

Survey costs are by fiscal years although most survey data collections are based on the calendar year. Depending on the periodicity of the survey, the costs in any given fiscal year may include some or all of the following: data processing costs (both in-house and through contracts) for the current, as well as the most recently completed collection cycle, and personnel and related costs for analyzing and disseminating data from previous cycles.

On-going Basic Data Collection - NCHS is the source of national data on vital events, including births, deaths, marriages, and divorces. The FY 1987 request will support activities involved in carrying out responsibilities which include the maintenance of a Nation-wide vital statistics network with the States, the analysis and presentation of this data in published documents, and the maintenance of centralized files of data for use of persons in the health care field. Examples of information produced through this system include infant mortality, low birth weight, cause of death, life expectancy, and family formation and dissolution. These statistics provide the base for charting the course and monitoring progress in many of the Nation's public health programs, as well as being of critical use in medical research. In FY 1987, an increase of $2,348,000 over the 1986 sequestered level will permit NCHS to maintain the percentage of Federal support of vital statistics data collection at approximately the FY 1986 level, restore a one-time savings to accommodate the 1986 sequestering, and acquire perinatal linked birth and death records from all States in order to provide needed data for an intensive investigation of the correlates of risk of prenatal and infant death.

Household Interview Statistics- Data with regard to the status of the Nation's health, the cost of health care maintenance and medical care, and the relative growth of U.S. families is obtained through three principal household surveys conducted by the Center in coordination with many other Federal agencies. To support the Center's share of the costs of these surveys, an increase of $104,000 is requested.

The National Medical Care Utilization and Expenditure Survey provides data on the use of, and charges for, medical care services in the United States. This survey provides a statistical base for monitoring trends and costs of health services for population groups such as the poor, elderly, and the uninsured. The survey collects data by conducting interviews of U.S. households based on national probability samples. The data collected by this survey are used to measure the impact of legislation and health insurance programs on the charges for and financing of health services and insurance costs. Users of this data are other staff of the Department of Health and Human Services, other Federal agencies, Congress, State and local governments, university faculties and public health students, and health related commerce. Analysis of data from the most recent survey will continue in FY 1987.

The National Health Interview Survey is a principal national source of data on the incidence of illness, prevalence of diseases and impairments, extent of disability, utilization of health care services, and other health related topics. The data gathered by this survey are used for planning and evaluating health programs, analyzing trends, measuring needs and resources and for other analyses related to health care. It is used by Department of Health and Human Services staff, other Federal agencies, Congress, State and local governments, university faculties involved in health education, and businesses involved with health-related services. Data processing and analysis will continue during FY 1987 on three major special survey supplements recently collected, focusing on health insurance, vitamin and mineral usage, and physical limitations to obtaining health care. The 1987 survey will include a supplement on cancer risk factors.

The National Survey of Family Growth provides national statistics on fertility, family planning, and the reproductive health of American women in the childbearing years. The FY 1987 request will support continued analysis of data from recent surveys, and includes funding for the 1987 cycle of the survey. Planning and development for this cycle of the National Survey of Family Growth was initiated in FY 1986. In addition to providing data to the health and demographic communities at large, the survey is designed to meet the specific data needs of the National Institute of Child Health and Human Development and the Office of Population Affairs. These agencies will collaborate in conducting the survey and share funding responsibility.

Health Examination Statistics - The 1987 request includes a net increase of $2,585,000 to continue support of this program. Information is gathered on the health and nutritional status of the nation through the conduct of actual on-site examinations of selected samples of the U.S. population on a periodic cyclical basis. The results of these surveys have been proven to be invaluable to individuals in the health care community.

The National Health and Nutrition Examination Survey (NHANES) is a periodic survey that assesses the health and nutritional status of the general population through the collection of data that can be obtained only, or best, by direct physician examination, clinical and laboratory tests and related measurement procedures. For example, neither provider records nor personal interviews reveal the extent of undiagnosed illness.

2. Health Statistics

In addition to policymakers and planners in Federal, state and local health agencies, users of NHANES data include health workers in the fields of nutrition, child health, medical education, environmental health and other health research. NHANES is a key component of the National Nutrition Monitoring System, an intergovernmental effort to obtain information concerning the nutritional status of the population. The data collection phase of the most recent NHANES was completed in 1980. The FY 1987 request supports costs associated with preparing for the data collection phase of the 1988 cycle of NHANES. Planning and development for this cycle of the Survey was initiated in FY 1986.

The Hispanic Health and Nutrition Examination Survey was a special, one-time survey of the Hispanic (Mexican American, Cuban American, and Puerto Rican) population to obtain an accurate and valid assessment of health and nutritional status and the health characteristics of this subgroup of the population. Information is now being provided from this survey on the growth and development of children; sources of, access to, and knowledge of health care; and nutritional status as it relates to health. Data collection was concluded in FY 1985. Analysis of the data and the release of reports and data tapes will continue in FY 1987.

Health Care Resources and Utilization Statistics - Continuing interest and concern on the part of State and local health planners, universities, insurance payors, and government agencies involved with the utilization, cost and quality of medical and health care institutions substantiates the need for the collection, analysis, and dissemination of data on the use of ambulatory medical health care services, the size and composition of populations in nursing homes, and sources of funds for care and hospital utilization. This information is obtained through three surveys: The National Hospital Discharge Survey, The National Ambulatory Medical Care Survey, and the National Nursing Home Survey. The funds requested in FY 1987 will enable the Center to support operating costs associated with these surveys.

Other Program Activities - The analysis and dissemination of data is equally as important as the gathering of data. Therefore, the Center is continuing the effort to actively pursue data collection methodology. This includes the adoption of current automation technologies, ongoing methods for quality control, the analysis and interpretation of data and release of data for public use. The FY 1987 request will continue these activities at approximately the same level as FY 1986.

The Analysis, Epidemiology, and Environmental Health Statistics program is the focal point for the conduct of in-depth analytic studies using data from NCHS surveys and data systems; the development of information on the effects of environmental, social, and other health hazards on the health of the population; the impact of illness and disability on the economy; and overall analysis and interpretation of statistics relevant to major national health issues. This program also develops the Department's annual health report to the Congress, *Health, U. S.*, the triennial *Prevention Profile* with data measuring progress in meeting the 1990 objectives for health promotion, and prepares special reports on selected health issues.

Public Health Service Management

2. Health Statistics

The Data Dissemination Services program supports the release of research findings from NCHS data systems, including the development, printing and dissemination of NCHS publications and computer data tapes to Federal, state, local, public and private organizations. NCHS also responds to over 150,000 inquiries each year from a wide range of users of health statistical data in both the private and public sectors.

Research toward improving survey design and analytical methods relating to NCHS projects and for identification and evaluation of the Center's statistical standards and quality control systems are supported in this activity.

Resources requested for NCHS in FY 1987 are 432 FTEs and $46,825,000, a net increase of $5,204,000 above the FY 1986 amount available after sequestering. The budget includes built-in costs of $257,000. The following table details these changes:

Built-In Costs:	
Within-grade increases	+$326,000
Merit and bonus pay	+104,000
PHS Service and Supply Fund Costs	-62,000
Standard Level User Charges	+9,700
Federal Telecommunications System	+5,600
Federal Employee Compensation Fund	+11,700
Research Triangle Park rent increase	+110,000
Management Savings	-248,000
Net Change	+$257,000
Periodic Survey Increases	+5,727,000
Periodic Survey Decreases	-780,000
Net Increase	+$5,204,000

Program Support

1987 Authorization: Indefinite

Budget Authority:

	1986 Appropriation	1986 Available After Sequestering	1987	Increase or Decrease
	$3,193,000	$3,056,000	$3,193,000	+$137,000
FTEs		54	54	0

Purpose and Method of Operation - This activity provides for the planning, coordination, management, and evaluation of vital, health and health related statistical programs. Included are the development of goals and objectives, the setting and administering of NCHS policies and procedures, and the direction and administration of a program of research in statistical analysis. Resources are also included to support the NCHS administrative management functions.

Public Health Service Management

2. Health Statistics

1987 Budget Proposal - In FY 1987 NCHS will continue to emphasize efficient and effective resources allocation and utilization, and improved performance reporting and monitoring. Special attention will be placed on long-range planning and scheduling of statistical activities, and improving the comparability and timeliness of data.

Resources requested for this activity in FY 1987 are 34 FTEs and $3,193,000.

Built-in Costs:

Within-grade increases	+$39,000
Merit and bonus pay	+19,000
PHS Service and Supply Fund Costs	-8,000
Standard Level User Charges	+1,300
Federal Telecommunications System	+800
Federal Employee Compensation Fund	+2,100
Research Triangle Park rent increase	+15,000
Restoration of restricted travel, training, and delayed equipment purchase	+67,800
TOTAL	+137,000

Public Health Service Management

---

3. Adolescent family life
(Public Health Service Act, Title III, Section 301 and Title XX, Section 2010. Section 2010 expired September 30, 1985. Extension legislation has been proposed. Current year funds are authorized under the 1986 Continuing Resolution, P.L. 99-190.)

1987 Authorization: Extension legislation proposed

Budget Authority:

	1986 Appropriation	1986 available after Sequestering	1987	Increase or Decrease
	$14,689,000 1/	$14,057,000 1/	$14,722,000	+$665,000
FTEs...		17	17	---

1/ $79,000 will be withheld from obligation pursuant to Section 513 of the Treasury-Postal Service, and General Government Appropriations Act, authorized under the 1986 Continuing Resolution, P.L. 99-190.

Purpose and Method of Operation

The objective of the Adolescent Family Life (AFL) program is the development of effective family-centered demonstration models designed to help prevent adolescent pregnancy and to alleviate its health, social, psychological and economic consequences. The program supports projects in communities throughout the country to demonstrate the effectiveness of providing comprehensive care services to pregnant adolescents, their infants and male partners and prevention services to encourage the postponement of adolescent premarital sexual activity. Priority is given to potential grantees for projects which are three years in duration, serve areas with high need for services, utilize existing available programs, use alternative funding sources, demonstrate community support and involvement, and demonstrate innovative approaches to solving the problem of adolescent pregnancy. Each AFL project is required to have an independent evaluation component to be, as a rule, affiliated with a College or University in the State being served. Results of these evaluations will be disseminated to States and communities throughout the country so that they may choose an appropriate model for their community.

A major emphasis of the program is to explore and develop approaches that maximize the guidance and support available to adolescents from parents and other family members so as to help their adolescents deal with their sexuality in responsible ways. Evidence suggests that family involvement and influence can delay teenage premarital sexual relations. For those adolescents who are already pregnant, the family should be the critical institution which assists the pregnant adolescent to deal with her pregnancy and complete her education.

BEST COPY AVAILABLE

Public Health Service Management

5. Adolescent Family Life

Care programs enable pregnant adolescents and adolescent parents to obtain proper health, social, and educational services to become productive independent contributors to family and community life; and to assist families of adolescents to understand and resolve the societal causes which are associated with adolescent pregnancy. Adoption is promoted as a viable alternative to early parenting for pregnant unmarried adolescents under 18 years of age. Prevention programs promote the postponement of adolescent premarital sexual relations by finding effective means within the context of the family of reaching adolescents before they become sexually active in order to maximize the guidance and support available to adolescents from parents and other family members.

Recipients of previous demonstration grant awards reflect a wide range of community models. For example, grantees funded by the program since its inception in FY 1982 have included public and private non-profit health and social service agencies, schools, national youth groups, hospitals, institutions of higher learning, and research foundations. To insure a genuine commitment on the part of the grantees, matching funds of at least 30% of the total cost of the projects are required for the first two years, 40% for the third year, 50% for the fourth year and 60% for the fifth and final year of the grant.

Research projects are building a base of knowledge which is being used by policy and service providers concerned with this problem. These projects explore such broad topics as the influences on adolescent premarital sexual behavior, consequences of adolescent premarital sexual behavior, consequences of adolescent premarital pregnancy, adoption as an option for the unmarried adolescent mother, and adolescent pregnancy services. Specific studies funded have included: the role of the family in deterring unwed parenting; the influences of parents, peers, and media on adolescent sexual behavior; factors which influence the adoption decision among adolescent females; and the effectiveness of services in reducing welfare dependency of adolescent parents.

1987 Budget Proposal

Funds are requested to continue support for those projects that are developing effective alternative approaches for preventing teenage pregnancy and improving services available to the already pregnant teenager and her family. To ensure that the knowledge gained by the grantees is disseminated outside the Federal government, the program will provide information for policy makers at the State and local level to assist them in determining the effectiveness of a variety of approaches that are applicable to their particular areas.

In addition to providing support for 56 demonstration and research continuations, the 1987 request will provide funding for 36 new demonstration models and 7 new research studies. Results of previously

Public Health Service Management

3. Adolescent Family Life

Funded AFL research studies will help determine the foci for new demonstration models. The new research studies will enable the program to follow up on questions which arise from the results of studies and demonstrations presently being funded by the program.

Impact Data	1985 Actual		FY 1986 after Sequestering		FY 1987	
	No.	Amount	No.	Amount	No.	Amount
Demonstration Grants for Care and Prevention Services:						
Continuations	62	$9,054,000	72	$9,362,000	64	$5,186,000
New	17	2,730,000	8	1,221,000	16	5,771,000
Subtotal............	(79)	(11,784,000)	(80)	(10,583,000)	(80)	(10,957,000)
Research Grants:						
Continuations	5	504,000	9	600,000	12	936,000
New	10	992,000	8	777,000	5	500,000
Subtotal..........	(15)	(1,496,000)	(17)	(1,377,000)	(17)	(1,436,000)
Total Grants.......	94	13,280,000	97	11,960,000	97	12,393,000
Project Contracts......	—	399,000	—	831,000	—	1,030,000
Total Program..	94	13,679,000	97	12,791,000	97	13,423,000
Program Support.........	—	1,151,000	—	1,266,000	—	1,299,000
TOTAL, AFL.........	94	$14,830,000	97	$14,057,000	97	$14,722,000

Resources requested for this activity in FY 1987 are $14,722,000 and 17 FTEs, an increase of $665,000 over the FY 1986 amount available after sequestering. This increase reflects the net change in dollar levels for the AFL grants and contracts program and the following built-in costs:

Built-in costs:	
Within-grade increases.................	+$10,000
Merit and bonus pay....................	+6,000
PHS Service and Supply Fund Costs....	-3,000
Federal telecommunications system....	+6,000
Federal employees compensation fund..	+1,000
Management Savings.....................	-7,000
Net change..............	+$13,000

Public Health Service Management

4. Special Health Initiatives: (a) Smoking and Health
(Public Health Service Act, Title III, Section 301.)

1987 Authorization: Indefinite

Budget Authority:

	1986 Appropriation	1986 Available after Sequestering	1987	Increase or Decrease
	$3,526,000 1/	$3,375,000 1/	$3,471,000	+$96,000
FTEs....		23	23	---

1/ $176,000 will be withheld from obligation pursuant to Section 515 of the Treasury, Postal Service, and General Government Appropriations Act, authorized under the 1986 Continuing Resolution, P.L. 99-190.

Purpose and Method of Operation

The Smoking and Health program serves as the focal point for all Departmental smoking and health activities. This activity is committed to the long-range goal of reducing premature deaths, disabilities and health care costs associated with cigarette smoking. The Department has identified this as one of the major means of improving the health of Americans.

Cigarette smoking is associated with approximately 350,000 deaths each year. While the percentage of adult smokers (30%) continues to decrease and is at the lowest level in 20 years, 55 million Americans still smoke. Direct health care costs are increased by $12-35 billion annually due to the smoking habit. Also, it is estimated that $25 billion in productivity is lost as a result of smoking. There is increasing evidence that smoking and its health and economic consequences can be reduced and eliminated by information and education programs designed to:

- Reduce the prevalence and the number of cigarette smokers in the general population.
- Reduce the number of women who smoke, especially those who are pregnant, take oral contraceptives or have increased risk of disease due to other factors.
- Reduce the number of children and adolescents who take up smoking.
- Reduce smoking among persons exposed to occupational health hazards, including asbestos.
- Reduce smoking in racial and ethnic minorities.
- Provide information on prevalence, attitudinal, epidemiologic, economic and other data on smoking for the purpose of research, planning and evaluation.

Public Health Service Management

3. Special health initiatives: (a) Smoking and health

The Smoking and Health program is committed to alerting both the general public and the health care professions to the harmful effects of cigarette smoking. Over 20,000 public inquiries and 7,000 technical information requests are answered annually. The Office produces and disseminates a number of scientific and technical smoking and health publications. In conjunction with the World Health Organization (WHO), the activity serves as one of the four existing WHO collaborative centers for smoking and health. The program compiles, analyzes, stores and disseminates, on a worldwide basis, international data on smoking. A collaborative program with the Federal Trade Commission informs the public of the tar, nicotine and carbon monoxide ratings of cigarettes. Award winning public service announcements have been developed for television and radio and placed throughout the country. Individual anti-smoking public service campaigns have been distributed to the metropolitan areas which constitute the major media markets. The Office staffs a national advisory committee on smoking and health.

1987 Budget Proposal

The FY 1987 request will continue support for the Federal efforts to encourage the reduction of cigarette-caused illness and death by informing the public of the hazards of smoking and by supporting the research community with essential data on smoking prevalence. The request will permit the Smoking and Health program to continue its ongoing efforts which focus on three major areas.

Public Information and Education Campaigns and Special Initiatives: The national public information campaign on television, radio and other media will be continued to assist and encourage current smokers to quit and others, particularly female adolescents, not to take up the habit. Two of the ten priority 1990 Objectives in the smoking and health area can only be achieved through intensive information and education efforts. The success of the current public information program is reflected in the continuing decline in per capita consumption. Over the last several years decreases in consumption have accompanied increased publicity of the health hazards of cigarette smoking. To further this downward trend, the activity will continue to develop cooperative information and education initiatives with the private sector. The Office is currently conducting information/media initiatives with health departments and national voluntary health organizations. Liaison is maintained with the major voluntary organizations such as the American Heart Association, American Lung Association, and the American Cancer Society.

Scientific and Technical Information: Maintenance of the Technical Information Center capabilities will be continued in order to service the research and public health communities. The Technical Information Center is a unique repository for information on tobacco, smoking and health. It provides the technical and information support and hard copy access to all studies cited in the Surgeon General's Report. The program maintains more than 50,000 titles and possesses the computer and microfilm technologies to provide special searches, references, abstracts and, in some cases, hard copies to researchers on request. Responses to approximately 5,000 technical inquiries and 40,000 public inquiries are provided each year. The activity will also continue developing the Department's report to the Congress on the health effects of smoking which has been prepared at their request since 1967. Approximately 12,000 copies of the Surgeon General's Annual Health Consequences Report are produced and distributed through this program. Other publications prepared and disseminated through this program include the Bibliography on Smoking and Health, Smoking and Health Bulletin, and the Directory of Ongoing Research in Smoking and Health.

Oversight and Coordination: The Office on Smoking and Health monitors, evaluates, and analyzes changes in smoking trends, attitudes and behavior for policy and program development. In 1987, the activity will continue working with other DHHS programs such as the Heart, Lung, and Blood Institute and the National Cancer Institute at NIH, and the National Center for Health Statistics to coordinate research efforts throughout the Department. The program is currently working with the Centers for Disease Control to assist states with the development of state-wide risk factor surveillance systems. Collaborative efforts are also undertaken with other Federal agencies including the Department of Agriculture and the Federal Trade Commission. For example, collaborative efforts with the FTC informs the public of the tar, nicotine, and carbon monoxide ratings of cigarettes. The Office will continue to staff a newly created national advisory committee and will produce publications such as State and Local Programs and the new biennial report to Congress.

The FY 1987 budget request would also support the work needed to carry out the Comprehensive Smoking Education Act of 1984 (P.L. 98-474). This law: (1) establishes four rotational health warnings for cigarette packages and advertising; (2) calls upon the Department to begin monitoring and evaluating cigarette additives; (3) provides authorization for the Department's educational programs relating to the effect of cigarette smoking on human health, including the requirement for the biennial report to Congress; and (4) establishes an Advisory Committee to coordinate Federal and non-federal smoking and health activities.

In FY 1987, this activity is requesting $3,471,000 and 17 FTEs, a net increase of $96,000 over the 1986 amount available after sequestering. The FY 1987 budget request includes a program increase of $139,000 for restoration of funding for smoking prevalence activities delayed in 1986.

Public Health Service Management

4. Special health initiatives: (a) Smoking and health

This increase is offset by a decrease of $43,000 for the following built-in costs:

Built-in costs:	
Within-grade increases.................	+$8,000
Merit and bonus pay....................	+6,000
Federal employees compensation fund...	+1,000
PHS Service and Supply Fund...........	-3,000
Management Savings.....................	-55,000
Net Change	-$43,000

B... AVAILABLE

4. Special health initiatives: (b) Disease prevention and health promotion (Public Health Service Act, Title III, Section 301.)

1987 Authorization: Indefinite

Budget Authority:

	1986 Appropriation	1986 Available after Sequestering	1987	Increase or Decrease
	$3,000,000 1/	$2,871,000 1/	$2,973,000	+$102,000
FTEs...		17	17	---

1/ $100,000 will be withheld from obligation pursuant to Section 515 of the Treasury, Postal Service, and General Government Appropriations Act, authorized under the 1986 Continuing Resolution, P.L. 99-190.

Purpose and Method of Operation

The Disease Prevention and Health Promotion activity is the central focus within the Department for the provision of national leadership and Departmental coordination for policies and programs in health promotion and disease prevention. This responsibility involves a number of program activities including: overseeing implementation of the 1990 prevention objectives; coordinating Departmental efforts in nutrition; disseminating health information to the public through the National Health Promotion Program and the National Health Information Clearinghouse; and encouraging health promotion, protection and preventive services programs in the public and private sectors. An important part of the responsibilities within this activity is enlisting the cooperation of other Federal departments, State and local health agencies and voluntary and private sector organizations in all facets of the Federal disease prevention and health promotion program.

The Federal government, through the Office of Disease Prevention and Health Promotion, is actively involved in stimulating and supporting local and national programs in health promotion, especially through the work of national private and voluntary organizations and business and industry. In 1987 the Office will continue monitoring progress toward achievement of the 227 health Objectives for the Nation first published in 1980. Following a midcourse review completed in 1986, the Office will give particular emphasis to those objectives of high priority which are unlikely to be achieved without renewed leadership attention. Concurrently, planning for revision of the Surgeon General's Report, Healthy People, and development of national health objectives for the year 2000 will begin.

In 1987, the Office will synthesize the work of a task force on delivery of preventive services in medical treatment settings, and publish recommendations for the specific screening, preventive and counseling interventions for each age group that should become standard practice in clinical health care settings.

1987 Budget Proposal

Prevention activities have been identified as the most promising area for future improvement in the health status of U.S. citizens. This activity represents the central focal point of the Department's policies and programs in health promotion and disease prevention. The FY 1987 budget request would permit this activity to continue its on-going efforts addressing the following areas:

1990 Objectives Initiative: In 1979 the Public Health Service issued a major agenda for the Nation in health promotion through the publication of Healthy People. Five specific goals for improving the health of the American people by 1990 were outlined, one for each of the major life stages: infancy, childhood, adolescence and young adulthood, adulthood, and older adulthood. The report also identified 15 priority areas within which more specific achievement could contribute to attainment of the stated goals. In 1980 this was followed with the publication of Promoting Health/Preventing Disease: Objectives for the Nation which identified 227 measurable objectives to meet the major goals established a year earlier. The FY 1987 request will permit the activity to focus special attention on objectives shown by the 1985-86 midcourse review to be falling short of attainment by 1990. The activity will update Federal implementation strategies for those selected objectives and will promote similar planning and program implementation on the part of State, local and private sector organizations.

Nutrition Initiative: The nutrition initiative of this activity works to strengthen the Department's capabilities and national leadership in nutrition research, monitoring, services and training, as well as food safety and quality, and international nutrition. Ongoing efforts include the Interagency Committee on Human Nutrition Research and the Joint DHHS/USDA Nutrition Monitoring Evaluation Committee. The Surgeon General's Report on Nutrition and Health, developed by this activity, documented significant relationships between diet and disease as well as other roles of nutrition in health protection, preventive interventions and health promotion. The FY 1987 request will permit the activity to follow-up on issues posed by the Surgeon General's Report, disseminating its findings to health policymakers and using the questions it posed to focus public and private scientific inquiry. In addition, new research findings will be monitored to make subsequent updates to the 1986 Report.

Public Health Service Management

4. Special health initiatives: (b) Disease prevention and health promotion

---

Clinical Preventive Services: This facet of the activity fosters the delivery of personal preventive services in clinical settings through work with major professional organizations, reimbursement organizations (such as insurance companies), and scientific groups. Efforts focus on identification of the most effective types of preventive health services for hospitals and physicians' offices and on assessment of the clinical and economic issues in the delivery of preventive services. In FY 1987, this activity will promote endorsement and implementation of the recommendations of the United States and Canadian Task Forces on Preventive Services through work with professional associations and private insurors. This effort will be the culmination of three years of joint scientific assessment by the task forces of the two nations with support from this activity and its counterpart in the Federal government of Canada.

National Health Information Clearinghouse (NHIC): The NHIC enables the Public Health Service to respond directly to requests for health information. Serving both the general public and health professionals, the NHIC receives about 3,000 requests each month. The requests are answered by retrieving information from its onsite library and database or by forwarding requests to other organizations for direct response. In FY 1987, the NHIC will also manage the Information Tracking System for data related to the 1990 Health Objectives for the Nation. The FY 1987 request will permit the NHIC to make available significant research findings and program guides in the area of health promotion and disease prevention.

In addition, the 1987 request will support the activity's continued development of public-private partnerships addressing the following areas:

Health Promotion: The activity will focus attention on continued support for the Healthy Older People program--a cooperative public/private effort to improve the health of older Americans; on worksite health promotion, with special concern in FY 1987 for employees of small businesses and minority workers; and on school health education, with completion and dissemination of a national study of health knowledge, attitudes and practices and the development of a model school health record.

Health Protection: The activity will extend recent Departmental capabilities to assess and quantify potential health risks in order to improve public understanding of the relative impacts of these risks.

Preventive Health Services: The activity will work cooperatively with associations of health professionals to improve professional education in disease prevention and health promotion, using the recommendations for age- and sex-specific packages of preventive services developed by the U.S. Task Force on Preventive Services.

As the principal staff office on prevention in the Public Health Service, this activity provides responsive support to the Offices of the Secretary, the Assistant Secretary for Health, and the Surgeon General on issues and programs related to disease prevention and health promotion.

Public Health Service Management

4. Special health initiatives: (b) Disease prevention and health promotion

---

This activity is requesting 17 FTEs and $2,973,000 in FY 1987, a net increase of $102,000 over the FY 1986 amount available after sequestering. The request includes a program increase of $119,000 for the National Health Information Clearinghouse to manage the Information Tracking System for data related to the 1990 Health Objectives for the Nation. This increase is offset by a decrease of $17,000 for the following built-in costs:

Built-in costs:	
Within-grade increases..........................	+$10,000
Merit and bonus pay.............................	+2,000
PHS Service and Supply Fund costs...............	-3,000
Federal employees compensation fund............	+1,000
Management Savings..............................	-27,000
Net change.................	-$17,000

Public Health Service Management

---

4. Special health initiatives: (c) Physical fitness and sports (Public Health Service Act, Title III, Section 301.)

1987 Authorization: Indefinite

Budget Authority:

	1986 Appropriation	1986 Available after Sequestering	1987	Increase or Decrease
	$1,379,000 1/	$1,320,000 1/	$1,361,000	+$41,000
FTEs...		15	15	---

1/ $16,000 will be withheld from obligation pursuant to section 515 of the Treasury, Postal Service, and General Government Appropriations Act, authorized under the Continuing Resolution for 1986, P.L. 99-190.

Purpose and Method of Operation

The purpose of this activity is to provide staff support and assistance for the President's Council on Physical Fitness and Sports which is responsible for a ten-point national program of physical fitness and sports as directed by Executive Order 12534. This program is strongly supported by the private sector which contributes services and materials to many of the PCPFS projects. Through continuing contact, the Council seeks to enlist the active support and assistance of individuals, civic groups, professional associations, sports groups and others to promote and improve the health of all Americans through regular participation in physical fitness and sports.

The 1987 budget request will also provide continued support for staff and program operations, including technical assistance to various organizations, public service campaigns, sports medicine symposiums, regional leadership training workshops, awards to youth for outstanding physical fitness achievement and publication of research information. The PCPFS will continue to plan and implement programs that carry out its directives to promote physical fitness for all age groups; establish Governors' Councils on Physical Fitness and Sports; urge employers to establish employee fitness programs; and encourage all Federal departments and agencies to support physical fitness programs for their personnel.

1987 Budget Proposal

The 1987 budget request will provide program emphasis on youth fitness as a follow-up to the National Youth Fitness Survey, the results of which are to be published in 1986. Other areas of particular emphasis are fitness for working women, older adults and special populations.

In FY 1987, this activity is requesting $1,361,000 and 15 FTEs, a net increase of $41,000 over the 1986 amount available after sequestering. This increase will provide funding for the restoration of items deferred in FY 1986 such as printing of publications and workshop materials.

Public Health Service Management

4. Special health initiatives: (c) Physical fitness and sports

---

The 1987 request includes the following built-in costs:

Built-in costs:	
Within-grade increases	+$6,000
Merit and bonus pay	+3,000
Federal employees compensation fund	+1,000
Service and supply fund	-1,000
Management Savings	-18,000
Total	-$9,000

Public Health Service Management

---

5. PHS management (Section 301 of the Public Health Service Act)

1987 Authorization: Indefinite

Budget Authority:

	1986 Appropriation	1986 Available After Sequestering	1987	Increase or Decrease
	$18,510,000	$17,714,000	$18,736,000	+$1,022,000
FTEs...		300	300	---

Purpose and Method of Operation

The purpose of this activity is to provide funding for the offices that support the Assistant Secretary for Health in providing executive leadership and direction to the Public Health Service (PHS). Under the direction of the Assistant Secretary for Health, the PHS agencies are responsible for the implementation of plans and strategies designed to accomplish National health goals. PHS efforts include research and development; manpower development and training; improving access to health care services; preventive health care; protection of the public from unsafe foods, drugs and medical devices; and Federal administration of the Health Block Grants. The Assistant Secretary for Health's responsibilities include formulating health policy; providing leadership, coordination, and direction of a nationwide program of disease prevention and health promotion; providing health care to Indian and Alaskan Natives; maintaining relationships with other Federal, State, and local governmental and private agencies concerned with health; providing policy guidance for health-related activities throughout the Department; and conducting international health affairs.

The staff offices funded by this activity assist the Assistant Secretary for Health in (1) the direction and coordination of all management activities of the Public Health Service; (2) the development of PHS policy and providing leadership and coordination of health agency activities in the areas of financial management, contracts and grants management, personnel management, organizational analysis, ADP management, and facilities management; (3) providing leadership and review of agency management activities for the purpose of assuring compliance with laws, regulations, departmental and PHS management policies, procedures, goals, and plans; (4) and, in providing related activities that assure the efficient as well as effective operation of the Public Health Service and its programs.

Public Health Service Management

5. PHS management

In 1987 this activity will continue to focus on a number of significant initiatives of importance to the Public Health Service. These include (1) In the area of debts collection, efforts to improve debt management practices and procedures will be continued, including reporting information on delinquent debts to credit bureaus, referring delinquent debts to collection agencies, and to the Internal Revenue Service (IRS) for collection by offset against Federal income tax refunds, referring written-off debts to the IRS for consideration as taxable income, and collection of debts by administrative action or salary offset. (2) The coordination of a comprehensive dissemination program designed to provide information to the American public regarding Acquired Immune Deficiency Syndrome (AIDS). The main objective of this effort is the provision of information sufficient to create a widespread awareness and understanding of the nature of AIDS, the probable cause and tests for detection, the suspected means of transmission, the relative threat posed to specific populations and the public health and precautions recommended to avoid contracting AIDS. (3) Implementation of the Federal Manager's Financial Integrity Act will continue. In FY 1987, we will continue to review and evaluate the internal control system in place for the prevention or detection of fraud, waste, and abuse. The staff will also monitor the corrective actions of material weaknesses identified in 1986 Internal Control Reviews, General Accounting Office, and HHS Inspector General audits and management studies. And, (4) In the area of organizational and management activities, efforts will be continued to develop new approaches to management processes that reduce paperwork duplication and overlapping responsibilities and costs.

FY 1987 Budget Proposal

The FY 1987 budget request will provide a level of support that will permit the staff offices to maintain activities in an effective manner. Resources requested for this activity in FY 1987 are 300 FTEs and $10,736,000, an increase of $1,022,000 over the 1986 amount available after sequestering. The net increase includes $174,000 for built-in costs and an increase of $848,000 for the restoration of funds required in FY 1987 for a variety of activities which were deferred from FY 1986 to FY 1987 including (1) the full-year costs of vacancies that were unfilled during FY 1986; the purchase of equipment to continue planned office automation; training to enhance the ability of employees to assume additional and different responsibilities; and travel for staff to participate in a variety of functions where representation of the Public Health Service by the Assistant Secretary for Health, the Surgeon General and others would be expected.

The FY 87 budget request of $10,736,000 and 300 FTEs includes built-in costs as follows:

Built-in cost:

Within-grade increases	+$100,000
PHS Service and Supply Fund Costs	+43,000
Federal Telecommunications System	+3,000
Federal Employees Compensation Fund	+8,000
Standard Level User Charge	+20,000
Net Changes	+174,000

Public Health Service Management

Detail of Permanent Positions

	1985 Actual	1986 Estimate	1987 Estimate
ES-6	2	2	2
ES-5	16	16	16
ES-4	1	3	3
ES-3	1	1	1
ES-1	1	2	2
Subtotal	21	22	22
GS/GM-15	88	91	93
GS/GM-14	132	127	126
GS/GM-13	160	150	159
GS-12	81	81	81
GS-11	58	56	61
GS-10	7	7	7
GS-9	53	55	50
GS-8	30	28	28
GS-7	91	93	93
GS-6	77	77	76
GS-5	68	65	60
GS-4	35	52	52
GS-3	6	6	6
GS-2	7	3	1
GS-1	—	—	—
Subtotal	[illegible]	864	864

Grades established by Act of July 1, 1944 (42 U.S.C. 207)

	1985 Actual	1986 Estimate	1987 Estimate
09	1	1	1
08	3	3	3
07	7	7	7
06	16	15	18
05	9	8	8
04	3	3	3
03	8	2	1
02	—	—	—
01	—	—	—
Subtotal	38	40	40
Total, permanent positions	901	926	926
Unfilled positions, end of year	1	—	—
Total permanent employment, end of year	900	926	926
Worker Trainee Opportunity Program Positions not included above	10	10	10

Public Health Service Management

Estimates for Consulting Services

Account Title	Type 1/	Source of Funds 2/	Obligations FY 1985 Actual	FY 1986 Current Estimate 3/	FY 1987 Estimate
Evaluation:					
Public Health Service Management	C	A	$707,580	$835,000	$835,000
Non-Evaluation:					
Public Health Service Management	C	A	87,875	91,000	91,000
	G	N	72,040	197,000	197,000
	P	A	31,489	116,000	116,000
	G	A	111,113	363,000	363,000
Subtotal, non-evaluation			(302,517)	(767,000)	(767,000)
Total, consulting services			$1,010,097	$1,602,000	$1,602,000

Totals:

	FY 1985 Actual	FY 1986 Current Estimate	FY 1987 Estimate
Contractual services	$795,455	$926,000	$926,000
Personnel appointments	31,489	116,000	116,000
Advisory committee expenses	183,153	560,000	560,000
Total, consulting services	$1,010,097	$1,602,000	$1,602,000

1/ C = Contractual Services
P = Personnel appointments
G = Advisory committees

2/ N = Non-appropriated
A = Appropriated

3/ Reflects a withholding of $47,000 under section 515 of the Treasury, Postal Service, and General Government Appropriation Act as authorized under the 1986 Continuing Resolution, P.L. 99-190.

Narrative Summary

Consultant services are required in many activities of OASH and are utilized when the specific expertise needed is not available and would not be required on a permanent basis. The employment of consultants under these circumstances minimizes the Federal investment in limited term projects while permitting the use of highly qualified experts. Specifically, consultants are used in the review of research and demonstration grants and contracts; the support of scientific consensus development conferences; and to provide specialized advice on a variety of topics.

The increase in FY 1986 contractual services over the FY 1985 level reflects the additional requirements of the National Center for Health Statistics in the planning and development of the next cycle of the National Health and Nutrition Examination Survey (NHANES). The same level of effort is required in FY 1987.

The increase in FY 1986 supportive consultant funds will allow the provision of needed review and advisory services during the planning and development stages of the 1987 National Medical Expenditure Survey (NMES). It also reflects the increased need for expert advisory services in developing a comprehensive evaluation activity for all Adolescent Family Life programs. The 1987 requirement for supportive consultants remains at the 1986 level.

Public Law 98-551, the "Health Promotion and Disease Prevention Amendments of 1984," signed by the President in October 1984, established the National Advisory Council on Health Care Technology Assessment. The increase in FY 1986 funds over the FY 1985 level for OASH advisory committees reflects the funds required to compensate the non-Federal Council members while they are engaged in the performance of the functions of the Council. The same level of support is anticipated in FY 1987.

Public Health Service Management

Obligations for Related Services

Account Title	Type 1/	Source of Funds 2/	Obligations FY 1985 Actual 3/	FY 1986 Current Estimate 4/	FY 1987 Estimate
Public Health Service Management	MP	[illegible]	[illegible]	[illegible]	[illegible]
	MP	[illegible]	[illegible]	[illegible]	[illegible]
	SS	[illegible]	[illegible]	[illegible]	[illegible]
	SS	[illegible]	[illegible]	[illegible]	[illegible]
Total, related services			[illegible]	[illegible]	[illegible]

1/ MP = Management and professional services
SS = Special studies and analysis

2/ [illegible]
[illegible]

3/ Reflects withholding of $[illegible] under section [illegible] of the [illegible] Treasury, Postal Service Appropriations Act.

4/ Reflects withholding of $[illegible] under section [illegible] of the 1986 Treasury, Postal Service, and General Government Appropriations Act as authorized under the 1986 Continuing Resolution, P.L. 99-190.

Narrative Summary

[illegible]

[illegible]

[illegible]

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF ASSISTANT SECRETARY FOR HEALTH

Priority Disease Control and Research Projects

FY 1987 Budget Page

Appropriation language and Explanation of language changes......... 56

Language Analysis.. 57

Amounts available for obligation..................................... 58

Summary of changes... 59

Budget authority by object... 60

Authorizing legislation.. 61

Table of estimates and appropriations................................ 62

Justification:

A. General statement... 63

B. Program accomplishments.. 63

C. Acquired Immune Deficiency Syndrome (AIDS)

1. CDC Activities.. 67
2. NIH Activities.. 70
3. ADAMHA Activities..................................... 75
4. Coordination Activities............................... 76

D. Detail of new positions.. 78

OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

Priority Disease Control and Research Projects

For carrying out Title III of the Public Health Service Act with respect to priority projects, $203,482,000 together with any other unobligated funds appropriated with the express intent of being used for research or control of Acquired Immune Deficiency Syndrome. Such amounts as the Secretary deems necessary may be transferred to this heading from funds available to the Public Health Service other than "Retirement Pay and Medical Benefits for Commissioned Officers": Provided, That the amount transferred from any such appropriation shall not exceed 1 percent of that appropriation.

Explanation of Language Changes

This language is being requested to provide funds in a new appropriation for research and education activities on Acquired Immune Deficiency Syndrome (AIDS) within the Office of the Assistant Secretary for Health. In Fiscal Years 1985 and 1986, AIDS was supported through funds appropriated directly to the Centers for Disease Control, the National Institutes of Health, and the Alcohol, Drug Abuse and Mental Health Administration.

Priority Disease Control and Research Projects

Language Analysis

Language Provision	Explanation
"For carrying out Title III of the Public Health Service Act with respect to priority projects, $203,482,000..."	Language provides funding for coordination, research and education activities on Acquired Immune Deficiency Syndrome.
"...together with any other unobligated funds appropriated with the express intent of being used for research or control of Acquired Immune Deficiency Syndrome..."	While no funds are estimated to remain unobligated, language would authorize any unobligated funds to be carried foward from appropriations in fiscal year 1986 and remain available in fiscal year 1987.
"Such amounts as the Secretary deems necessary may be transferred to this heading from funds available to the Public Health Service other than "Retirement Pay and Medical Benefits for Commissioned Officers": Provided, That the amount transferred from any such appropriation shall not exceed 1 percent of that appropriation."	Language would provide authority to the Secretary to utilize up to 1 percent of all Public Health Service appropriated funds with the exception of the "Retirement Pay and Medical Benefits for Commissioned Officers" account.

Priority Disease Control and Research Projects

Amounts Available for Obligation

	1985 Actual	1986 Estimate	1987 Estimate
Appropriation..................	---	---	$203,482,000
Comparative transfer from:			
Health Resources and Services Administration for: Acquired Immune Deficiency Syndrome Activities..........	$5,000,000	---	---
Centers for Disease Control for: Acquired Immune Deficiency Syndrome Activities..........	$28,298,000	$50,285,000	---
National Institutes of Health for: Acquired Immune Deficiency Syndrome Activities..........	63,737,000	120,757,000	---
Alcohol, Drug Abuse and Mental Health Administration for: Acquired Immune Deficiency Syndrome Activities..........	2,578,000	12,158,000	---
Subtotal, adjusted budget authority....................	99,613,000	183,200,000	203,482,000
Total obligations.............	99,613,000	183,200,000	203,482,000

Priority Disease Control and Research Projects

Summary of Changes

1986 Estimated budget authority	$183,200,000
1987 Estimated budget authority	$203,482,000
Net change	+20,282,000

	1986 Base	Change from Base
Increases		
Program:		
1. Increase will support an expansion in AIDS research and intensify testing of potentially effective vacines and drugs therapies	$176,597,000	+$25,535,000
2. Program Coordination To support a staff of 5 FTEs to coordinate the National AIDS effort, including coordination of the PHS programs utilizing prevention and research resources of the Centers for Disease Control, the Alcohol, Drug Abuse and Mental Health Administration and the National Institutes of Health.	---	+$1,350,000
Subtotal		26,885,000
Decreases:		
Built-in:		
1. Decrease due to non-recurring cost associated with the FY 1986 purchase of active antiviral agents for treatment of AIDS patients.	6,603,000	-6,603,000
Subtotal		-6,603,000
Net change		+20,282,000

Priority Disease Control and Research Projects

Budget Authority by Object

	1986 Appropriation	1986 Current Estimate	1987 Estimate	Increase or Decrease
Total number of full-time permanent positions...........	---	---	5	+5
Total compensable workyears:				
Full-time equivalent employment	---	---	5	+5
Full-time equivalent of overtime and holiday hours..	---	---	---	---
Average ES salary..............	---	---	$70,500	+$70,500
Average GS grade...............	---	---	10.5	+10.5
Average GS salary..............	---	---	$34,000	+$34,000
Personnel compensation:				
Full-time permanent..........	---	---	$209,000	+$209,000
Personnel benefits.............	---	---	32,000	+32,000
Travel and transportation of persons........................	---	---	16,000	+16,000
Other services.................	---	$183,200,000	203,225,000	+20,025,000
Total budget authority by object................	---	183,200,000	203,482,000	+20,282,000

Priority Disease Control and Research Projects

Authorizing Legislation

	1986 Amount Authorized	1986 Current Estimate	1987 Amount Authorized	1987 Budget Request
Priority Disease Control and Research PHSA section 301	Indefinite	$183,200,000	Indefinite	$203,482,000

Priority Disease Control and Research Projects

Table of Estimates and Appropriations

Year	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
1987	$203,482,000			

Priority Disease Control and Research Projects

Justification

	FY 1986 Estimate		FY 1987 Estimate		Increase or Decrease	
	FTE	Amount	FTE	Amount	FTE	Amount
AIDS...........	---	$183,200,000	5	$203,482,000	+5	+$20,282,000

(Excludes $9,527,000 in 1986 and $9,765,000 in 1987 for the Food and Drug Administration; Agriculture, Rural Development, and Related Agencies Appropriation.)

General Statement

Acquired Immune Deficiency Syndrome (AIDS) is a viral disease which causes a complex of health problems deriving from a defect in a person's natural immunity against selected diseases and direct action of the virus on a person's central nervous system. As a result, persons with AIDS are vulnerable to infections which would not be a threat to those whose immune system was functioning normally. The appearance of these opportunistic diseases triggers a diagnosis of AIDS. Patients are gradually weakened by these diseases and eventually die.

AIDS has become a disease of epidemic proportions and a public health problem unprecedented in recent history. For example, the number of cases of AIDS doubled between February 1985 and January 1986. The total number of cases as of mid February was over 17,500. Over half of these patients have died and not one has recovered lost immunity. For those diagnosed with AIDS for two years or longer, the mortality rate is over 85 percent.

Based on epidemiologic studies of certain high risk groups, scientists have estimated that many more people are infected with the AIDS virus than actually have the disease itself. These studies suggest that approximately one million persons in the United States are infected with the AIDS virus. Approximately 5 to 10 percent of individuals will go on to develop AIDS within five years after becoming infected with the virus. About 25 percent will go on to develop AIDS related complex (ARC), a milder form of the disease marked by swollen lymph glands, within the same time frame. Once infected, individuals harbor the virus for life and are capable of transmitting it to others. These infected individuals are likely to remain at risk of developing AIDS or ARC and can develop the disease as long as seven years after exposure to the virus.

Since 1982 when statistics were first collected, the distribution of cases among risk groups has not changed markedly. The disease is still largely confined to two groups in the United States: homosexual or bisexual men (74 percent) and IV drug abusers (17 percent). There is some overlap (about 8 percent) between the two groups.

Program Accomplishments

Soon after the disease was first recognized, a PHS coordinating group was established to bring the scientific resources of all PHS agencies to bear on the problem. After the AIDS virus was discovered the PHS Executive Task Force on AIDS was formed. The Task Force meets biweekly and is an important forum to communicate, coordinate, review policy and formulate future plans for combatting this dread disease. It is currently chaired by the PHS AIDS coordinator.

There has been a considerable amount of progress made to date. Epidemiological studies conducted since the disease was first reported in 1981 have defined the following routes of transmission:

- Sexual contact from infected male to male (now the predominant form of transmission) and from infected males to females and infected females to males;
- Exposure to infected blood through sharing of needles among I.V. drug use, contaminated blood transfusions or other blood components; and
- Perinatally, from infected mother to infant.

The AIDS virus has been isolated from blood, semen, saliva, tears, and urine. Although it may be isolated from other body fluids, secretions, and excretions, epidemiologic evidence has implicated only blood and sexual contact in transmission.

Studies of over 300 household contacts of AIDS patients and studies of 1,758 health care workers in facilities where AIDS patients are treated suggest that AIDS is not spread by casual contact, such as sneezing, coughing or sharing of meals.

These findings have formed the basis for recommendations dealing with the safety of the blood supply, personal behavior as a preventive measure, and use of the blood screening test. In addition, the PHS has worked with many public and private organizations to develop guidelines to assist State and local officials to make decisions on how to protect the public health. These guidelines are based on the best available scientific evidence and are updated as new data become available. In August 1985, PHS issued guidelines that recommended most AIDS-infected children should be allowed to attend school. In November 1985, PHS issued guidelines for the prevention of AIDS in the workplace with emphasis on health care, food service, and personal service workers. The guidelines state that the kind of nonsexual person-to-person contact that occurs among workers and clients or consumers in the workplace does not pose a risk for transmission of AIDS. In December 1985, PHS issued guidelines on the prevention of perinatal transmission of the AIDS virus.

In 1984, a retrovirus, human T-lymphotropic virus, type III (HTLV-III) was identified as the cause of AIDS. It is unusual to have the cause of a disease identified so quickly, especially, as in the case of AIDS, where discovery of a new agent was involved. Basic research findings already made in the field of cancer virology greatly aided this effort. Scientists have now made significant progress in describing the structure of the virus and understanding its effect in man.

Discovery of the AIDS virus allowed PHS to develop a test for use in blood banks and plasma centers to prevent transmission of the disease through transfusions of blood and blood products. In March 1985, two commercial manufacturers were licensed to market the HTLV-III antibody test, which is now used to test every unit of blood or plasma in the United States. There are currently five companies licensed to market the test. In a recent CDC study, the test was 97.8 percent sensitive (ability of test to be positive for those infected) and 99.8 percent specific (ability of test to be negative for those not infected). The speed with which this procedure moved from being a research tool to mass application in the testing of millions of units of blood and plasma has set a new record for product development, licensure and general use. This advance along with processes for heat and chemical treatments that kill the virus in blood products used to treat hemophilia, assure that the blood supply is essentially safe. Because of the long incubation period of AIDS, however, we will continue to hear of new cases in hemophiliacs and recipients of blood transfusions who were infected before the antibody test and other prevention measures were available.

The search for new drugs and a potential vaccine continues. A drug development program, including expanded clinical trials, for AIDS therapeutics has been established at the National Institutes of Health. So far, hundreds of candidate compounds have been screened and seven have FDA approval for testing in AIDS patients. Regrettably, there is currently no effective treatment for those with AIDS, although therapies do exist to treat some of the opportunistic diseases associated with AIDS. Clinical research scientists believe that ultimately a combination of two drugs may be required, one to treat the underlying immune deficiency and another to stop replication of the virus.

Vaccine development is under way. The NIH is preparing a safe subunit vaccine that would contain only the viral proteins against which protective antibodies are made. The major viral glycoprotein , the target for antibodies which inactivate the virus, has been isolated in quantity. This subunit is being tested in animals and neutralizing antibodies have already been detected. At present, there is no candidate vaccine for human testing.

Purpose and Method of Operations

The purpose of this request is to continue to expand the intensive AIDS research and control effort. Acquired Immune Deficiency Syndrome continues to be the highest public health priority of the Department of Health and Human Services. The Federal effort includes health education and risk prevention as well as research on the causes of and potential treatment for AIDS. The Federal effort in health education and risk reduction is largely carried out through extramural activities of the CDC and through contracts with State and local health organizations. The Federal research effort is largely carried out through intramural activities of the National Institutes of Health and through research project grants and contracts with the Nation's biomedical research organizations.

In September 1985, as a part of the effort to combat AIDS, PHS published an outline of a Plan for the Prevention and Control of AIDS. It takes advantage of and extends discoveries made to date. The approach has three basic program objectives:

cc

- Expand research efforts to develop effective therapies and a vaccine;
- Implement a major public education effort to encourage behavioral changes; and
- Continue efforts to clarify the epidemiology and natural history of the disease.

Rationale for Budget Request

The 1987 request for AIDS (excluding FDA) is $213.5 million. This is an increase of $[illegible] million over the level being requested in 1986. This increase will be used principally for expanding research activities at the National Institutes of Health. This request meets all of PHS's identified needs for AIDS research at this point in our understanding of the disease.

In 1987, PHS will continue its important work in AIDS research pursuing all promising avenues. The primary emphasis, as is currently the case, will be on development of agents to treat the disease and vaccines to prevent it. With the establishment of 14 new Drug Treatment Evaluation Units in 1986, it is anticipated that additional numbers of AIDS patients will be able to receive most advanced treatment available under research protocols. As information on vaccine development continues to accumulate, advances are expected in this vital area. AIDS activities will also continue to focus on AIDS-related laboratory investigations, surveillance, epidemiologic studies, technology transfer, information dissemination, and prevention and control projects. These activities provide information on the extent and distribution of AIDS, groups at increased risk for AIDS, risk factors, the etiology of the syndrome, and risk reduction measures. PHS would also continue providing technical assistance and information to treatment and service providers on the methods and procedures to care for the mental health needs of AIDS patients.

The current PHS resource plan and the detailed accomplishments and plans for 1986 and 1987 of the various PHS agencies follow:

	1986	1987	Change
Centers for Disease Control........	[illegible]	[illegible]	[illegible]
National Institutes of Health......	128,767,000	142,000,000	+13,233,000
Alcohol, Drug Abuse and Mental Health Administration............	12,150,000	13,725,000	+1,575,000
Office of the Assistant Secretary for Health..........................	---	1,250,000	+1,250,000
Total, PHS (excluding FDA)....	[illegible]	[illegible]	[illegible]

In 1987, the PHS is requesting Congress to approve a single appropriation to support the Federal AIDS effort previously supported under separate appropriations for NIH, CDC and ADAMHA. This request also requests authority to permit the Secretary to transfer, if needed, up to 1 percent of funding from lower priority programs to AIDS research and control. The PHS has recently appointed an AIDS coordinator under the Assistant Secretary for Health, with responsibility for coordinating the multifaceted AIDS program. The Coordinator would be responsible for reviewing the total PHS operation and spending plans. However, the operational responsibilities will continue to reside in the individual agencies involved.

In summary, this request of a single appropriation, funding transfer authority, and the appointment of a permanent AIDS coordinator will enable the PHS to be more responsive to changing priorities resulting from any new opportunities including specific breakthroughs in AIDS research and prevention.

Centers for Disease Control

In 1986 and 1987, CDC will continue to focus on: national surveillance of AIDS; national and international epidemiologic studies to identify new risk factors and further define modes of transmission; development and evaluation of prevention strategies; assessment of serologic and other diagnostic tests; development of an animal model and participation in approaches for vaccine development and evaluation; transfer of technology to the medical and public health communities for widespread application; and provision of AIDS prevention information and education to scientific and public health communities, high-risk groups, and the public, in support of the overall goal to prevent the transmission of AIDS.

Cooperative agreements will continue with State and local health departments in high incidence areas to conduct active surveillance and related epidemiologic investigations. CDC will continue to monitor and analyze national trends in AIDS incidence by geographic area and risk group, including active surveillance of patients with hemophilia and pediatric AIDS, to identify risk factors and patterns of transmission and to formulate prevention strategies.

To further define risk factors for AIDS transmission, CDC will conduct epidemiologic studies of: (1) risk factors for transmission among a cohort of homosexual men in San Francisco; (2) risks among family members of heterosexual AIDS patients; (3) AIDS patients reported not to belong to known risk groups; (4) blood donors to patients with transfusion-associated AIDS; (5) recipients of blood from persons with AIDS or infection with human T-lymphotropic virus (HTLV-III); (6) risk from nonparenteral exposures to patients with AIDS among health care and laboratory workers; (7) prevalence of HTLV-III antibody in risk group members, their sexual partners and household contacts; (8) AIDS in Zaire; and (9) prostitutes and heterosexual transmission.

CDC will continue laboratory investigations of HTLV-III to: (1) provide viral isolation, serologic, and immunologic support for epidemiologic studies; (2) assess sensitivity and specificity of serologic tests; (3) determine variation among virus isolates from different geographic areas as a basis for possible variability in the patterns of host response and pathogenicity; (4) determine whether detection of virus protein and/or nucleic acid sequences are useful in rapid diagnosis of infection; (5) correlate clinical and epidemiological findings with antibody to AIDS virus and positive cultures of this agent; (6) determine the immunologic response to infection with AIDS virus; (7) determine susceptibility of AIDS virus to disinfectants and environmental conditions; (8) continue studies of primates and other animals who are infected with AIDS virus to clarify the natural history of infection; and (4) participate in approaches for vaccine development and evaluation.

As laboratory technology becomes available, it is being transferred to laboratory personnel in the private and the public health sectors who are trained to perform diagnostic procedures. Improved screening and diagnostic capabilities will permit the identification of individuals with less severe or even asymptomatic infection. An effect of this technology transfer will be a significant increase in identified infections, thus expanding prevention efforts.

CDC continues to modify prevention recommendations for risk groups, health-care workers and professionals, and the public. CDC prevention recommendations to reduce the risk of AIDS transmission were first issued in November 1982 and March 1983. Since that time, nine additional major guidelines have been developed and distributed related to prevention of AIDS and HTLV-III transmission. Other interim guidelines have been published as new information became available. Ongoing epidemiologic research continues to clarify and quantify the risk of AIDS for main groups and identify specific behaviors or susceptibility factors. The results of this research are being translated into additional prevention efforts which will be carefully evaluated in multiple settings. CDC will continue to fund and provide technical assistance to the U.S. Conference of Mayors national AIDS information interchange system among city governments. The exchange program will make timely and appropriate information about AIDS available to Mayors and local health officials, especially in high impact cities.

The strategy to control spread of HTLV-III is influenced by five crucial facts: 1) no effective therapies exist to eliminate the virus or correct the process in the infected persons; 2) there is no vaccine to prevent susceptible persons from acquiring infection; 3) an infected individual may be able to transmit the virus continually, or intermittently, throughout his or her lifetime; 4) spread of the virus results from a few personal behaviors which, when altered, can reduce the possibility to a minimum; and 5) HTLV-III infection is the first modern infectious disease causing significant morbidity and mortality for which health education is the only instrument available to carry out an aggressive public health control effort.

The goal of the control strategy, therefore, is to reduce HTLV-III transmission by influencing the behavior of people in three specific population groups. The primary effort is to apply individually targeted health education messages to persons who are already infected so they will adopt behaviors that reduce their risk of spreading the virus to others. Second, the strategy aims to deliver risk reduction messages that will help prevent infection in people who are uninfected but whose current personal behaviors place them at high risk of acquiring an infection. Third, the strategy is designed to reach the general public with timely and accurate information that defuses unjustified fears, facilitates rational behavior toward all aspects of the AIDS problem, and promotes constructive support for the control efforts of public health officials.

Implementing this strategy requires focused and cooperative community-based programs which coordinate the delivery of targeted AIDS health education, plus risk reduction messages and support services necessary to reinforce them. CDC will award cooperative agreements in 1986 to help develop this capacity, and intensify control efforts in high morbidity areas.

Health education techniques dominate the current strategy for controlling transmission of HTLV-III and probably would continue to play a pervasive role even with the development of effective therapies and/or a vaccine. Therefore, it is essential to identify the most effective methods of applying these techniques, test them and other evolving control measures under actual program conditions, and disseminate information to assure all States can focus their energies and resources on approaches that truly work. To accomplish these ends, CDC will award up to eight cooperative agreements for research into innovative risk reduction approaches and up to eight new and continuation cooperative agreements supporting community-based demonstration projects for AIDS prevention and risk reduction.

Hemophiliacs are a special group at high risk for HTLV-III infection and AIDS. For most, their initial acquisition of the virus was unavoidable; further transmission from and among this group, however, can be prevented. Consistent with Congressional intent, CDC plans to provide funding for a national AIDS educational effort directed at hemophiliacs and will collaborate with the National Hemophilia Foundation and its national network of Comprehensive Hemophilia Treatment Centers in carrying this out.

Among the more specific accomplishments of the CDC in recent months are the following:

- Discovered the homing mechanism used by the AIDS virus to infect white blood cells, improves chances that a vaccine can be developed against the deadly disease.
- Completed a study of family members of 39 AIDS patients at Montefiore Medical Center in New York City. This study provides both strong evidence that "casual" transmission of HTLV-III does not occur and important support for guidelines on the care of AIDS patients and the education of children with AIDS.
- Evaluated sensitivity and specificity of HTLV-III antibody test among blood donors.
- Developed and distributed guidelines for AIDS among school and foster care children.
- Characterized the etiologic agent of AIDS using microbiologic, serologic, and immunologic techniques.
- Described unique ultrastructural findings in electron microscope studies of tissues from AIDS patients.
- Provided training for public health laboratories in conducting Elisa (HTLV-III antibody) and Western blot tests.

- Completed a case-control study of risk factors for AIDS among Haitians living in New York City and Miami through cooperative agreements.

- Continued a study of persons transfused with blood components donated by persons who subsequently developed AIDS or related disorders.

- Analyzed surveillance data to provide accurate information on AIDS trends and patterns and to detect any newly emerging risk groups.

- Conducted studies of recipients of Factor VIII and IX concentrate.

The 1987 request of $45,409,000 includes a net decrease of $4,876,000 below 1986. The decrease is due to non-recurring the two year cost associated with the one-time purchase of active antiviral agents for the treatment of AIDS patients not included in NIH clinical trials provided for in the 1986 appropriation. Once researchers determine that a drug is effective in the treatment of AIDS, but before Phase III Clinical Trials have been completed, it is important to make the drug available to those AIDS patients who cannot be enrolled in formal clinical trials since AIDS is rapidly fatal. Once safety and efficacy is clearly demonstrated, the drug will be made available under a Treatment Investigational New Drug application. Provision of the drug will be contingent upon agreement by the institution/physician to adhere to the study protocol and provide specified information on safety and efficacy.

National Institutes of Health

Since the spring of 1984 when scientists discovered the virus that causes AIDS, NIH has directed its efforts toward other important research questions aimed at preventing, treating, and curing the disease. Several NIH components are involved in AIDS research, through support of extramural projects and/or intramural studies. The National Cancer Institute (NCI) and the National Institute of Allergy and Infectious Diseases (NIAID) are the primary research components involved in the AIDS program, with the National Heart, Lung, and Blood Institute (NHLBI) also making a major commitment. Also involved are the National Institute of Dental Research (NIDR), the National Institute of Neurological and Communicative Disorders and Stroke (NINCDS), the National Institute of Child Health and Human Development (NICHD), the National Eye Institute (NEI), and the Division of Research Resources (DRR). The NIH Clinical Center continues in an important role; to date, more than 300 AIDS patients have been studied and treated there.

Building on a strong foundation of basic knowledge in immunology, virology, and molecular biology, scientists involved in AIDS research have advanced our understanding of AIDS greatly in the four years since the identification of the disease. In addition, a long-standing national commitment to training research scientists has assured the existence of a cadre of researchers around the country who have been ready to apply their expertise to the challenge posed by AIDS.

Currently, the NIH effort against AIDS is primarily aimed at development of agents to treat the disease and vaccines to prevent it. Important adjuvant research includes continued epidemiologic studies of the natural history of the disease, and a variety of basic research studies are ongoing.

Major program initiatives are being undertaken in 1986 to expedite the discovery, development, and testing of drugs against AIDS, with particular emphasis on the involvement of the extramural scientific/medical community and additional AIDS patients in these efforts. In a joint project undertaken by NCI and NIAID, drugs are being screened for their antiviral properties using an NCI-developed assay. So far, hundreds of candidate compounds have been screened for AIDS activity, and seven are in the early phases of clinical evaluation at NIH and elsewhere. In order to expand treatment and treatment-related studies around the country, the NCI and NIAID issued a solicitation in December 1985 requesting applications for funding National Cooperative Drug Discovery Groups. The resulting awards will be aimed at the preclinical discovery of effective agents to interfere with virus replication of function and to restore or maintain immune responses. The NIH and NIAID have also issued a joint solicitation for the establishment of AIDS Treatment Evaluation Units. Studies at these units will involve testing of antivirals, immune modulators, and antibiotics in patients with AIDS and AIDS Related Complex (ARC).

To speed information about new therapeutic agents to researchers and physicians treating AIDS patients, the NEI recently added data on AIDS treatment protocols to the Physician Data Query (PDQ) system. When fully operational, the system will give physicians around the country access--through personal computers or word processors with telephone hookups -- to information on the most promising AIDS therapies, locations of experimental treatment projects, and the names of AIDS specialists.

Among the more specific accomplishments of the NIH in recent months are the following:

National Cancer Institute

- The causative agent, HTLV-III, was molecularly cloned and characterized. This enabled scientists to compare closely and study the different isolates of HTLV-III and to make direct comparisons of its sequence with that of other retroviruses.
- The entire genetic structure (genome) of the virus was mapped. From analyses of the genomes of HTLV-III and other retrovirus, scientists confirmed that the AIDS virus is a new virus in humans.
- Scientists found the first direct evidence that HTLV-III can by itself destroy the white blood cells (helper T cells) that are the primary target of AIDS. This study proved that the virus does not necessarily need interaction with other disease "co-factors" to destroy these immune system cells.
- Scientists also learned that the HTLV family of retroviruses possesses a unique strategy for usurping the host cell's cellular machinery. This represents an entirely new type of regulatory mechanism for activating cells to produce more virus.
- In laboratory tests, a virus related to, or identical to, HTLV-III was detected in serum samples collected in Uganda in 1972 and 1973. This suggests that the virus may be a predecessor of HTLV-III or is HTLV-III, and that AIDS may have originated in Africa.

- o Neutralizing, or protective, antibodies, have been detected in some people who had been exposed to HTLV-III. The antibody's existence shows that our bodies are able to respond immunologically to HTLV-III in a way that may lead to new prevention and treatment approaches.

- o Other isolates of a virus that is very similar to HTLV-III, called STLV-III (simian T-cell lymphotropic virus) have been obtained, analyzed, and successfully used to infect rhesus monkeys. The identification of such a virus in animals and the ability to transmit it is an important step toward development of an animal model for AIDS.

- o Numerous epidemiologic studies are being pursued, leading to several important findings on the natural history of the disease: frequent male homosexual contact with residents of areas where AIDS is common may be an important means of spread of the causal agent; the virus is seldom transmitted through nonsexual contact, even when someone is stuck with a contaminated needle; there is no evidence of infection among household members of hemophiliacs other than sexual partners of hemophiliacs who have been infected with HTLV-III; and an association may exist between frequency of cytomegalovirus infection and Kaposi's sarcoma among some AIDS risk groups.

- o Major emphasis was placed on identifying and testing antiviral agents that may be effective against HTLV-III.

  -- Clinical trials involving suramin were begun at six institutions.

  -- Primary feasibility studies using azidothymidine, or Compound S, are promising. Compound S is not in Clinical training.

  -- Other therapies are being tested at NIH and around the country. These include anticancer drugs and immunorestorative agents such as interferon and interleukin-2.

  -- Researchers have discovered evidence of HTLV-III infection in the central nervous system of AIDS patients. This finding has major implications for treatment of AIDS because it indicates that the brain is a sanctuary for HTLV-III and that effective therapies must pass the blood-brain barrier.

- o Looking at the various isolates of HTLV-III, scientists found extensive diversity in their genetic structure, particularly in their envelope genes. The envelope genes code for the protein that elicits neutralizing antibodies in some infected individuals. Consequently, variations in the envelope may mean that antibodies developed against one HTLV-III variant would not protect against a wide spectrum of other variants, perhaps making development of an effective vaccine more difficult.

- o A vaccine development program has been initiated. The NCI is preparing a safe subunit vaccine that would contain only the viral proteins against which protective antibodies are made. The major viral glycoprotein , the target for antibodies which inactivate the virus, has been isolated in quantity. This subunit is being tested in animals and neutralizing antibodies have already been detected.

National Heart, Lung, and Blood Institute

- Studies are underway to determine the natural history of HTLV-III infection among blood donors and their recipients. More than 200,000 donors from whom serum specimens have been collected have agreed to be tested and contacted for further evaluation.

- Investigators have found that the risk of infection among blood recipients decreases as the time increases between blood donation and the development of AIDS in the donor.

- Research continues to be supported on the development of simpler, more rapid and sensitive assays than the one currently in use to detect antibody to HTLV-III in blood.

National Institute of Dental Research

- Clinicians have found that oral viral or fungal infections or Kaposi's sarcoma lesions are frequently the first manifestation of AIDS in a patient.

- Early studies showed that lymphocytes, which play a key role in the body's defense system, are suppressed in AIDS patients. Researchers have identified another defective cell in the immune system of AIDS patients -- the monocyte. They have found that the failure of monocytes to provide proper defense against foreign organisms in AIDS patients contributes to the rampant infections and unrestricted growth of tumors often seen in these patients. Drugs are being investigated that may restore the ability of monocytes to combat infections and tumor cells.

- Researchers have shown that cytomegalovirus causes life-threatening enteritis and colitis in AIDS patients. Use of the new agent DHPG is effective in controlling these gastrointestinal manifestations.

National Institute of Neurological and Communicative Disorders and Stroke

- Investigators have discovered that approximately 45 percent of AIDS patients develop AIDS encephalopathy, a noninflammatory destruction of brain tissue that results in dementia. This brain disease is caused by the AIDS virus.

- The first evidence of early neurological complications associated with the AIDS virus was found this year. This finding suggests that patients who harbor the virus may develop neurologic disease before, or along with, AIDS itself.

- Efforts are continuing on the development of a useful animal model for AIDS; among those being studies are chimpanzees, horses, and rhesus monkeys.

- Researchers have developed two possible SAIDS vaccines. The investigators hope that development of a SAIDS vaccine will provide valuable information about the procedures needed to develop a vaccine against AIDS.

National Institute of Allergy and Infectious Diseases

- Investigators have pinpointed the critical immunologic defect resulting from attack by the AIDS virus. They found that the virus selectively destroys or inactivates a particular subset of the lymphocytes that are responsible for the induction and regulation of the body's immune function. They also confirmed that other T lymphocytes, called suppressors, continue to operate normally. Thus, the essential immune defect in AIDS patients is a lack of helper function rather than overabundant suppressor function.
- Studies are being conducted using a combination of antiviral drugs and immune enhancers in several sets of twins. Each twin with AIDS receives suramin to suppress the virus, and transfusions of lymphocites and bone marrow from the healthy twin. If successful, this approach could serve as a model treatment regimen in other AIDS patients.
- Interleukin-2 has been found to cause an increase in lymphocyte count and a minor reduction in Kaposi's sarcoma tumors. These changes provide firm evidence that IL-2 may play an important role in potential combination treatment regimens.
- In preliminary studies with suramin, investigators have found that the virus level fell in some patients and became undetectable in others. Other antiviral substances being tested include foscarnet, ribavirin, and HPA-23.
- Recent findings have supported previous evidence that only a relatively small proportion of persons who are exposed to the AIDS virus will actually develop the disease.
- Data from epidemiological studies suggest that prevalence of HTLV-III antibodies in homosexual men varies across the United States, that transmission is occurring at a high rate, and that homosexual men can probably reduce their risk of AIDS by decreasing the numbers and altering the types of their sexual contacts.
- A prospective investigation is under way regarding the risk of transmission of AIDS virus to people sharing households (but not sexual contact) with adult AIDS patients. To date, the investigators have concluded that, even after prolonged contact with patients with AIDS, people sharing their households are at minimal risk for non-sexual transmission of HTLV-III transmission.

National Eye Institute

- Investigators found that the AIDS virus could be detected in the tears of a patient with this disease, and also in the outer layer of the conjunctiva, the transparent membrane that covers the white of the eye and the inside of the eyelids.

- The possibility that cells containing HTLV-III are sloughed off into tears or onto instruments that contact the eye was reported to the Centers for Disease Control. The CDC responded by outlining precautions to be taken to prevent spread of the virus through tears and ophthalmic instruments.

- There is no evidence to date that the disease can be transmitted through casual contact with tears of affected individuals, nor through medical instruments used to examine them.

- In studies of AIDS-associated ocular infections, researchers have found that the antiviral drug, DHPG, is effective in cytomegalovirus retinitis, but the response is transient with relapses occurring as soon as the drug is discontinued.

Division of Research Resources

- Major abnormalities in adrenal function have been identified in AIDS patients. Many AIDS symptoms, including weight loss, nausea, vomiting, and debilitation, could be specific effects of adrenal insufficiency. If so, the replacement of adrenal hormones could be beneficial.

- Simian AIDS is being studied extensively. Researchers have recently suggested that African green monkeys may have transmitted the STLV-III virus to man, and that the major proteins apparently shared by this virus and HTLV-III may be very important in developing a vaccine to prevent AIDS.

The 1987 request of $163,990,000 includes a net increase of $22,233,000 above 1986. In 1987, NIH will continue its important work in AIDS research pursuing all promising avenues. The primary emphasis, as is currently the case, will be on development of agents to treat the disease and vaccines to prevent it. With the 1986 establishment of 10 new Drug Treatment Evaluation Units, it is anticipated that additional numbers of AIDS patients will be able to receive the most advanced treatment available under research protocols. As information on vaccine development continues to accumulate, advances are expected in this vital area.

Additional projects being considered for 1987 include the following: evaluation of current blood screening tests and development of new ones; new studies on AIDS transmission; expanded efforts in vaccine development; and the establishment of a National Chimpanzee Management Plan designed to create a dedicated reserve of breeding animals to guarantee a supply of chimpanzees, which constitute the only currently available animal model for testing candidate AIDS vaccines.

Alcohol, Drug Abuse, and Mental Health Administration

Research on AIDS is supported within ADAMHA by two of its institutes, the National Institute of Mental Health (NIMH) and the National Institute on Drug

Abuse (NIDA). NIMH awards grants and contracts to support efforts directed toward understanding and assessing the psychiatric, behavioral and psychosocial aspects of AIDS. This includes identifying those persons most at risk for the development of AIDS, identifying those psychological and behavioral factors which may negatively or positively influence the course of the illness, and finally, identifying the relationship between the immune function and mental health status, such as depression, anxiety or responses to high levels of stress.

NIDA's AIDS-related grants and contracts support research activities directed towards assessing the spread of HTLV-III and towards addressing the needs in drug users already infected by HTLV-III, or symptomatic of AIDS. The Institute's activities focus on three principal populations: (1) drug users currently infected with HTLV-III; (2) other drug users at high risk of and concerned about the disease; and (3) drug abuse treatment and service providers. The Institute is also concerned with developing more effective prevention measures which will incorporate the increased knowledge about HTLV-III disease and assist in stopping the spread of AIDS to other populations.

The 1987 request of $13,733,000 includes a net increase of $1,575,000 above 1986. The current 1987 plan would enable both institutes to continue all ongoing research efforts as well as increase support for technical assistance and information dissemination activities related to AIDS. Specifically, NIMH proposes to initiate activities which are designed to address the mental health consequences of those already affected by AIDS, as well as the concerns of their families and associates, and provide technical assistance and information to treatment and service providers on the methods and procedures to care for the mental health needs of AIDS patients.

NIDA proposes the following efforts designed to control the spread of HTLV-III virus; particularly as it relates to IV drug users.

- Continue to clarify the epidemiology and natural history of HTLV-III infection in IV drug users,
- Stimulate and conduct research and development of effective prevention approaches and treatment agents,
- Implement national, state, and community prevention and education programs as prevention and control measures.

Office of the Assistant Secretary for Health

For the AIDS activities planned in the Office of the Assistant Secretary for Health (OASH) for 1987 we are requesting $1,350,000.

This request includes $350,000 and 5 FTEs to support the PHS AIDS Coordinator and support personnel. The PHS AIDS Coordinator chairs the PHS Executive Task Force on AIDS. This Task Force is the principal forum to communicate; coordinate; review progress, plans and policy; and formulate new plans and policy. The AIDS Coordinator would serve as the PHS focal point for coordinating, reviewing, and monitoring AIDS research plans and activities and would facilitate the resolution of the major AIDS issues facing the PHS. The

Coordinator, serving under the Assistant Secretary for Health, would be responsible for identifying gaps in activities, reviewing new proposals and making decisions essential for continued progress against this dreadful disease.

Specific resources ($350,000) are being requested to permit improved effectiveness of the PHS coordination effort in 1987. During 1986, approximately $200,000 is being provided for this effort by the PHS Agencies (FDA - $8,000, CDC - $54,000, NIH - $126,000, and ADAMHA - $12,000.)

This request also includes $1,000,000 to significantly expand the National AIDS Public Information Campaign. Since 1983, the PHS has carried out activities to inform segments of the American public about the relative risks of AIDS. For 1987, the program objective is to improve the American public's awareness and understanding of the nature of AIDS, its suspected means of transmission, the relative threat it poses to various populations and to the public health. The aim of this program ultimately is to help prevent and control this disease, by informing the public about specific behaviors to reduce the threat to individuals. The program effort involves coordination of all information activities carried out by the PHS agencies, as well as filling in gaps in these activities. In addition, coordination of a National Coalition of AIDS information and education will be expanded to gain maximum benefit from the activities of the many public and private sector groups involved.

The 1987 request of $1,000,000 represents an increase of $750,000 over estimated 1986 plans. The current 1986 plan of $250,000 is being supported by the PHS agencies (FDA - $10,000, CDC - $70,000, NIH - $155,000, and ADAMHA - $15,000.)

Priority Disease Control and Research Projects

Detail of Permanent Positions

	1985 Actual	1986 Estimate	1987 Estimate
ED-5	---	---	1
GS14	---	---	1
GS13	---	---	1
GS9	---	---	1
GS 6	---	---	1
	---	---	5

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

Retirement Pay and Medical Benefits for Commissioned Officers

FY 1987 Budget Page

Appropriation language and explanation of language changes 81

Language analysis.. 82

Amounts available for obligation......................... 83

Summary of changes....................................... 84

Budget authority by activity............................. 85

Budget authority by object............................... 86

Authorizing legislation.................................. 87

Table of estimates and appropriations.................... 88

Account summary.. 89

Justification:

A. General Statement..................................... 89
B. Retirement Payments................................... 90
C. Survivors' Benefits................................... 91
D. Medical Care.. 92
E. Reserve Fund.. 93

Retirement Pay and Medical Benefits for Commissioned Officers

For retirement pay and medical benefits of Public Health Service Commissioned Officers as authorized by law, and for payments under the Retired Serviceman's Family Protection Plan and Survivor Benefit Plan and for medical care of dependents and retired personnel under the Dependents' Medical Care Act (10 U.S.C., ch. 55), [such amounts as may be required during the current fiscal year] *not to exceed* [illegible]*, in addition $1,000,000 which shall be available only to the extent necessary to pay retirement pay and medical benefits not anticipated in the budget estimates.* 1/ *(Department of Health and Human Services Appropriation Act, 1986.)*

Explanation of Language Changes

1/ The Administration is proposing a definite appropriation for this account.

B[illegible] COPY AVAILABLE

Retirement Pay and Medical Benefits for Commissioned Officers

Language Analysis

Language Provision	Explanation
"... not to exceed $[illegible]."	The Administration is proposing to change the nature of this account from an indefinite to a definite appropriation. A reserve fund is included to enable the Department to meet any unanticipated program needs. A reserve fund is necessary because the benefits are entitlements.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

Retirement Pay and Medical Benefits for Commissioned Officers

Amounts Available for Obligation

	1985 Actual	1986	1987
Appropriation...........	$71,770,000	$[illegible]	$[illegible]
Sequester order.........	---	-[illegible]	---
Total obligations....	71,770,000	[illegible]	[illegible]

Retirement Pay and Medical Benefits for Commissioned Officers

Summary of Changes

1986 Estimate	$83,514,000
1986 Sequester order	-2,708,000
Total estimated budget authority	80,806,000
1987 Request	91,282,000
Net change	+$10,476,000

	1986 Base		Change from Base	
	Pos. (FTE)	Amount	Pos. (FTE)	Amount
Increases:				
A. Built-in:				
1. Annualization costs of additional retirees during 1986 and a net increase of 78 retirees during 1987	---	$67,996,000	---	+$2,172,000
2. Annualization and a net increase of 10 survivors receiving benefits	---	3,450,000	---	+113,000
3. Projected increase in costs of medical care.	---	9,360,000	---	+969,000
4. Cost-of-living adjustment of 4 percent to be effective January 1, 1987 for retirees and survivors	---	---	---	+2,222,000
5. Increase to establish a reserve required as a result of the proposed change from an indefinite to a definite appropriation	---	---	---	5,000,000
Total increases				$10,476,000

Retirement Pay and Medical Benefits for Commissioned Officers

Budget Authority by Activity

	1986 Appropriation	1986 Available after Sequestering	1987
Retirement payments.......	$70,169,000	$67,996,000	$72,282,000
Survivors' benefits.......	3,564,000	3,450,000	3,671,000
Medical care..............	9,781,000	9,360,000	10,329,000
Reserve fund..............	---	---	5,000,000
Total........	83,514,000	80,806,000	91,282,000

Retirement Pay and Medical Benefits for Commissioned Officers

Budget Authority by Object

	1985	1986	1987
Benefits for former personnel................	$62,487,000	$71,446,000	$80,953,000
Other services.............	9,287,000	9,360,000	10,329,000
Total budget authority by object....................	71,774,000	80,806,000 1/	91,282,000

1/ Reflects a reduction of $2,708,000 pursuant to the Balanced Budget and Emergency Deficit Control Act of 1985, P.L. 99-177

Retirement Pay and Medical Benefits for Commissioned Officers

Authorizing Legislation

		1986 Amount Authorized	1986 After Sequestering	1987 Amount Authorized	1987 Estimate
1.	Retirement payments Chapter 6A of Title 42, U.S.C.	Indefinite	$67,996,000	Indefinite	$72,282,000
2.	Survivors' benefits Chapter 73 of Title 10, U.S.C.	Indefinite	3,450,000	Indefinite	3,671,000
3.	Medical care Chapter 55 of Title 10 U.S.C., P.L. 89-614	Indefinite	9,360,000	Indefinite	10,329,000
4.	Reserve fund Above Titles	Indefinite	---	Indefinite	5,000,000

Retirement Pay and Medical Benefits for Commissioned Officers

Table of Estimates and Appropriations

Year	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
1977	$52,352,000	$52,352,000	$52,352,000	$52,352,000
1978	56,948,000	56,948,000	56,948,000	57,407,000
1979	65,083,000	65,083,000	65,083,000	65,555,000
1980	76,925,000	76,925,000	76,925,000	75,808,000
1981	91,958,000	91,958,000	91,958,000	81,679,000
1982	106,172,000	106,172,000	106,172,000	105,941,000
1983	85,433,000	77,102,000	77,102,000	71,325,000
1984	78,883,000	74,438,000	74,438,000	73,750,000
1985	86,448,000	78,589,000	78,589,000	71,774,000
1986	97,129,000	83,514,000	83,514,000	83,514,000
1986 Sequester	-2,708,000			
1987	91,282,000			

Retirement Pay and Medical Benefits for Commissioned Officers

Account Summary

	1985	1986	1987
Retirement payments..........	$59,473,000	$67,996,000	$72,282,000
Survivors' benefits..........	3,014,000	3,450,000	3,671,000
Medical care.......	9,287,000	9,360,000	10,329,000
Reserve fund.......	---	---	5,000,000
Total budget authority.....	71,774,000	80,806,000 1/	91,282,000

1/ Reflects a reduction of $2,708,000 pursuant to the Balanced Budget and Emergency Deficit Control Act of 1985, P.L. 99-177.

General Statement

This appropriation provides for retirement payments to Public Health Service (PHS) officers who are retired for age, disability, or a specified length of service as well as for payments to survivors of deceased retired officers who had received reduced retirement payments.

In addition, this account funds the provision of medical care to active duty and retired members of the PHS Commissioned Corps, and to dependents of active duty, retired and deceased members of the PHS Commissioned Corps.

The 1987 request includes an increase of $10,476,000 over the 1986 level. This increase reflects $2,222,000 for a cost-of-living adjustment of 4 percent to be effective January 1, 1987 for retirees and survivors. Also included are increased medical benefits costs and an annualization of amounts paid to retirees and survivors in 1986 and a net increase in the number of retirees and survivors during 1987.

Because definite budget authority is requested in 1987, a reserve of $5,000,000 is included in the 1987 estimate for unanticipated costs.

NOTE:

Subsequent to preparation of the President's Budget, a legislative proposal was developed to defer enactment of the 1987 cost-of-living adjustment.

Retirement Payments

Authorizing legislation - Chapter 6A of Title 42 U.S.C.

1987 Authorization: Indefinite

Budget Authority:

1986 Appropriation	1986 Available After Sequestering	1987	Increase or Decrease
$70,169,000	$67,996,000	$72,282,000	+$4,286,000

Purpose and Method of Operation

The purpose of this activity is to provide mandatory payments to Commissioned Officers of the Public Health Service who have been retired for age, disability or specified length of service.

1987 Budget Proposal

The 1987 request of $72,282,000, which is an increase of $4,286,000 over the 1986 level, will support payments to 2,289 retired officers. The 1987 request includes $2,114,000 for a 4 percent cost-of-living adjustment to be effective January 1, 1987 and $2,172,000 for annualization of payments for 1986 retirees and a net increase of 78 retirees during 1987.

The FY 1987 estimate is based on payments to the following number of retirees:

Period Ending	Total	Net Increase
September 30, 1985, actual	2,133	N/A
September 30, 1986, (est.)	2,211	78
September 30, 1987, (est.)	2,289	78

NOTE:

Subsequent to preparation of the President's Budget, a legislative proposal was developed to defer enactment of the 1987 cost-of-living adjustment.

Survivors' Benefits

Authorizing legislation - Chapter 73 of Title 10 U.S.C.

1987 Authorization: Indefinite

Budget Authority:

1986 Appropriation	1986 Available After Sequestering	1987	Increase or Decrease
$3,564,000	$3,450,000	$3,671,000	+$221,000

Purpose and Method of Operation

This activity provides for the payment of annuities to survivors of retired officers who had elected to receive reduced retirement payments under the Retired Serviceman's Family Protection Plan and Survivor's Benefit Plan. This program is financed by the Federal Government although deductions are made in the retirement payments to the officers who elect the option of survivors' benefits.

1987 Budget Proposal

The 1987 request of $3,671,000, which is an increase of $221,000 over the 1986 level, will provide payments for an estimated 309 annuitants. The 1987 request includes $108,000 for a cost-of-living adjustment of 4 percent to be effective January 1, 1987 and $113,000 for annualization costs and a net increase of 10 survivors receiving benefits.

The FY 1987 estimate is based on payments to the following numbers of annuitants:

Period Ending	Total	Net Increase
September 30, 1985, actual	289	N/A
September 30, 1986, (est.)	299	10
September 30, 1987, (est.)	309	10

NOTE:

Subsequent to preparation of the President's Budget, a legislative proposal was developed to defer enactment of the 1987 cost-of-living adjustment.

Medical Care

Authorizing legislation - Chapter 55 of Title 10 U.S.C.

1987 Authorization: Indefinite

Budget Authority:

1986 Appropriation	1986 Available After Sequestering	1987	Increase or Decrease
$9,781,000	$9,360,000	$10,329,000	+$969,000

Purpose and Method of Operation

This program provides for the cost of medical care rendered in non-Federal and in uniformed service facilities to active duty and retired PHS commissioned officers and dependents of eligible personnel.

This activity fulfills the mandatory medical care obligations of the Public Health Service to Commissioned Officers and their dependents. Medical care to eligible beneficiaries is authorized under the Dependents' Medical Care Act, as amended by P.L. 89-614, which allows for an expanded and uniform program of medical care to active duty and retired members of the uniformed services, and dependents of active duty, retired and deceased members. Health care provided in a uniformed service facility is billed directly to the Public Health Service by that organization. When medical care is provided to dependents or retirees in a private facility, the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) acts as the Government's agent to arrange payment and, in turn, bills the Public Health Service for the services rendered. In addition, contract medical care is arranged for active duty officers who are not stationed in an area accessible to uniformed facilities.

1987 Budget Proposal

The request of $10,329,000 will provide medical care for approximately 25,000 eligible beneficiaries. The FY 1987 request reflects increases in the cost of drugs and inpatient and outpatient care for all beneficiaries in Federal and non-Federal facilities. No workload increases are projected.

The FY 1987 estimate is based upon the following workloads:

Period	Average Inpatients Per Day	Outpatients Claims
1985	28	46,414
1986	28	46,414
1987	28	46,414

Reserve Fund

Authorizing legislation - Chapter 6A of Title 42 U.S.C., Chapter 73 of Title 10 U.S.C., and Chapter 55 of Title 10 U.S.C.

1987 Authorization: Indefinite

Budget Authority:

1986 Appropriation	1986 Available After Sequestering	1987	Increase or Decrease
----	----	$5,000,000	+$5,000,000

Purpose and Method of Operation

The purpose of this activity is to create a reserve fund which shall be available only to the extent necessary to pay retirement pay and medical benefits not anticipated in the budget estimate. This is an entitlement account; the payment for all costs are mandatory.

1987 Budget Proposal

The Administration is proposing a definite appropriation for this account. A reserve fund of $5,000,000 is requested to meet unanticipated program needs.

WITNESSES

Page
Archer, Loran 257
Augustine, Kent 257
Bennett, Dr. J. V. 537
Dowdle, Dr. Walter 749
Feinleib, Dr. Manning 749
Forbush, W. J. 749
Frazier, Sherwert 257
Gasper, Jo Ann 749
Goody, Edward 257
Hatch, T. D. 1
Hayes, Asahel 749
Hopkins, Dr. D. R. 537
Houk, Dr. Vernon 537
Hutchins, V. L. 1
Kelso, J. L. 1
Lane, Dr. J. M. 537
Little, W. H. 749
MacDonald, Dr. D. I. 749
Marshall, J. E. 749
Martin, E. D. 1
Mason, Dr. J. O. 537
McGinnis, Dr. J. M. 749
Millar, Dr. J. D. 537
Nickens, Dr. Herbert 749
Pickelsimer, C. F., *Jr.* 537
Pittman, James 257
Prescott, Dr. 257
Schuster, Charles 257
Shopland, Donald 749
Tolsma, Dennis 537
Trachtenberg, R. L. 257
Walsh, J. A. 1
Whitesin, D. F. 1
Williams, D. P. 1, 257, 537, 749

1008

INDEX

Alcohol, Drug Abuse and Mental Health Administration

Page

ADM Treatment Financing 292
ADMS Block Grant 279
AIDS After Sequester 358
AIDS Research 320
AIDS 352, 355
Allocation of Additional Funding 306
Alzheimer's Disease 353
Anniversary of NIMH 299
Authorizing Legislation 317
Block Grants 326
Clinical Training 297, 341, 365
Community Support Program 277
CSP 360
Death of SEH Patient 316
Decrease in Centers 306
Demand Reduction 317
Diagnostic Approaches 292
District of Columbia Support for SEH 312
Dixon Case 313
Drug Abuse Data Collection 322
Drug Abuse Prevention and Treatment Programs 277
Drug Abuse Services Within the Block Grant 279
Drug Testing 319
Economic Costs to Society 279
Elderly 354
Facility Study 315
Federal Obligation for Support of SEH 311
FTE Reductions 299
Funding for Alcoholism Research 300
Funding for Other Research Mechanisms 297
FY 1987 Funding Levels 364
Historically Black Colleges and Universities 297
Homeless 358
IOM Study Recommendations 365
Justification of Budget Estimates 367
Magnetic Resonance Activities 324
Massachusetts 1st Congressional District Awards 332
Mental Health Clinical Training 290
Mental Health Services to the Elderly 359
Minority Health Problems 292
Minority Personnel in NIMH 295

1009

Page
Minority Research Programs 299
Minority Research Training 291
Minority Training and Research 353
Monitoring of Minority-Related Research 296
NIAAA Demonstration Authority 329
NIAAA Intramural Program 323
NIAAA Monitoring Study 326
NIAAA Patient Placement Research 291
NIAAA Research Balance 329
NIAAA Research Centers 329
NIMH Clinical Research Centers 345
NIMH Minority Research 297
NIMH Reorganization 333
NIMH Research Priorities 342
Outplacement 313
Payback Issue 291
Prevention Education Efforts 352
Proposed 1986 Rescissions 290
Protection and Advocacy 307
Public Psychiatric Initiative 301
Public Psychiatry 357
Quality of Research 286
Reductions in SEH Patient Load 312
Representative Projects Relating to Rape and Child Abuse 302
Research Centers 294, 299, 306
Research Grant Shortfall 297
Research Grants 282, 288
Research on Sexual Victimization 301
Research Trainees 288, 326
Research Training Stipends 326
Restoration of NIAAA Grants to the 1985 Levels 294
Restoration of NIDA Grants to the 1985 Level 293
Restoration of NIMH Grants to the 1985 Level 293
Restoration to Pre-Sequestration Levels 289
Saint Elizabeths Hospital 310
Schizophrenia Initiative 325
Severity Index for Alcoholism and Drug Abuse 295
Stabilization of Research Grants 276, 308
Statement of the Administrator 265
Statement of the Director, National Institute of Mental Health on Saint Elizabeths Hospital 308
Status of SEH Transfer 302
Support of Black Colleges and Universities 296
Task Force of Black and Minority Health 297
Task Force on Reimbursement 329
Testing of Federal Employees for Drug Abuse 279
Treatment for Cocaine Addiction 330
Use of Clinical Training Funds 302
Use of SEH Land 314

Assistant Secretary for Health

Acquired Immune Deficiency Syndrome (AIDS) 825, 847, 849, 858, 867

Page
Adolescent Family Life Accomplishments 815
Adolescent Family Life Program 806, 861, 862
Adolescent Family Life Research Projects 913, 914
Adolescent Family Life Staffing 807
AFL Program Support Costs 807
Agency Budget Appeal Processes 858, 859
AIDS Apportionment Process 817, 818
AIDS Appropriation Language 776, 777, 778
AIDS Budget Coordination 803
AIDS Cases in Florida 769, 770
AIDS Coordination 818, 819
AIDS Coordination Plan 781, 788
AIDS Coordinator 779, 780, 858
AIDS Cure 820
AIDS Cure—Unused Funds 821, 822
AIDS: DOD Collaboration 855, 856
AIDS Education and Risk Reduction 813, 814
AIDS Executive Task Force 776, 777
AIDS Information Clearinghouse 851, 852
AIDS Off-Site Test Program 773
AIDS Program Consolidation 769
AIDS Public and Private Sector Programs and Initiatives 850, 851
AIDS Public Information Campaign 805, 806
AIDS Rescissions 805
AIDS—Rescission Determination 848
AIDS Research Coordination 860
AIDS Research Efforts 801, 802
AIDS Resources in DOD 778, 779
AIDS Technical Assistance 851
AIDS Travel Funds 860
AIDS Treatment Programs 773, 774
Allocation of AIDS Funds 857, 858
Allocation of AIDS Funds to Agencies 821
Analysis of User Liaison Program Expenditures 871, 872
Appointment of Permanent ASH 758
Black Health Task Force 877, 878
Budget Overview 750
Catastrophic Illness 822, 823
Childhood Immunization 774, 775
Cigarette Safety Act 814, 815
Commissioned Corps 758, 759
Commissioned Officers—Special Pay 760-765
Consolidation of Funding 792
Costs of Workshops and Seminars 863-866
Demonstration Projects 807
Diabetes in Minorities 853
Duties of the Surgeon General 758
Effect of Budget Proposals on Scope of Planned Studies 838, 839
Effect of Gramm-Rudman-Hollings in Title X 809, 810
Evaluation Funds 831, 832, 835, 836, 837
Feasibility of Health Services Research Centers as a Substitute for the User Liaison Program 866, 867
Gramm-Rudman-Hollings Reduction 766

Page
Health Care and Care Delivery Systems 849
Health Services Research Centers 800, 801
Hospitalization Denied for Reye's Syndrome Patient 775, 776
Infant Mortality 797, 798
Intramural and Extramural Activities 818
Introduction of Witnesses 749, 750
Jackson Memorial Hospital 711, 772
Justification of Budget Estimates 916
Kemp-Hatch Amendment 793–796
Letters of Support for User Liaison Program 867–861
Medical Malpractice 874, 875
National Center for Health Statistics FY 1987 Budget Increases 826, 827
National Medical Expenditure Survey 808, 809, 837
National Nutrition Monitoring System 828
National Vital Statistics 877
Natural Family Planning 811a
NCHSR and NCHS Budget Increase 811, 812
NCHSR Budget Increase 808
NCHSR Off-Budget Resources 812
NCHSR Support of User Liaison Program 866
Need for Additional AIDS Resources 779
New and Ongoing AIDS Activities 817
Nursing Home Insurance 909, 910
Nutrition Initiative 829, 830, 831
OASH Travel Increase 833
Office of International Health 879–907
Office of Minority Health 852
Office of Minority Health Funding 796, 797
Office of Minority Health Staffing 853, 854
Pertussis Vaccine 775
Physical Fitness and Health 914, 115
PHS AIDS Coordinator Staffing 819, 820
Preventive Health Initiatives 908, 909
Public Health Service Acquired Immune Deficiency Syndrome Funding 804
Public Health Service Management Effects of Sequestration 767, 768, 768a
Public Health Service Plan for the Prevention and Control of AIDS 789–791
Purchase of Non-Profit Hospitals 875, 976
Questions of the Relative Effectiveness of the User Liaison Program as Compared to Other NCHSR Activities 873, 874
Reductions in the FY 1986 NCHS Budget 827
Retired Pay Cola 769
Retirement Payments 834
Secretary's Position on AIDS Coordination 802, 803
Smoking and Health Activities 828
Special Foreign Currency Program 878, 879
Statement by the Acting Assistant Secretary for Health on Budget Request for OASH 751–757
Status of the Office of Minority Health 797
Studies on Health Care Expenditures 839–846
Surgeon General's Study on AIDS 780

1012

Page
Technical Assistance to Maryland 800
Teenage Pregnancy 809, 815, 816, 912, 913
Title X 911, 912
Title X Data Collection 810, 811
Title X Regulations 792, 793
Unauthorized Programs 766
User Liaison Contractors 823, 824
User Liaison Program 799, 800, 813, 823
User Liaison Program Reduction 812, 813
User Liaison Program Staffing 863
Variations in Medical Care 837, 838, 876
Voluntary Family Planning 912
World Health Organization 878
1990 Health Objectives 798, 799
7½% Evaluation Set-Aside 826

Centers for Disease Control

AIDS Allocation 641
AIDS Budget 632, 641
AIDS Capacity Building Grants 620
AIDS Cooperative Agreements for Hemophilia 639
AIDS Education and Prevention 621
AIDS Education and Risk Reduction 633
AIDS FTEs 641
AIDS Rescission 599, 622
AIDS and Chlamydia Control 643
AIDS and Other STD Activities 639, 661
AIDS, Alternate Test Sites Funding 598
AIDS, Appropriated Funds 595
AIDS, Blood Transfusions 655
AIDS, Budget Reduction—Effect 609
AIDS, Casual Transmission 600
AIDS, Centralized Funding 619
AIDS, Diversion of Resources 585, 642, 661
AIDS, Effect of Alternate Test Site Rescission 601
AIDS, Funding Mechanism 604
AIDS, Incidence in the United States 552
AIDS, Infection Rates in Prostitutes 610
AIDS, Plans for 1986 597
AIDS, Plans for 1987 596
AIDS, Problem Severity 595
AIDS, Safer Practices Promotion 599
AIDS, Sequestration of Funding 620
AIDS, Simian 601
AIDS, Transmission by Intravenous Drug Use 589
AIDS, Vaccine Development 587
AIDS, Work with the Hemophilia Foundation 627
Agent Orange Study 619, 664
Black and Minority Health Report 627, 648
Budget Request Highlights 537
Centers for Health Promotion and Disease Prevention 653
Chancroid 588
Chlamydia 587, 642
Chlamydia Control—Effect of Gramm-Rudman [illegible]13

Page
Chlamydia, Reporting 654
Chlamydia, Test 644
Chlamydia, Future Control 663
Chlamydia, Number of Infections 664
Chronic and Environmental Diseases 649
Community Health Promotion Program, Effects 555
DTP Vaccine 656
Designer Drug Studies 594
Diabetes Among Minority Americans 628
Diabetes Control Program 653
Diabetes State Control Projects 629, 636, 668
Dioxin Effects on Workers 604
Drug Enforcement Administration, Cooperation 590
Ectopic Pregnancy 654
Educational Resource Centers, Funding 591, 616, 666
Educational Resource Centers, Training 644
Employment by Budget Activity 567
Gonorrhea 608
Gonorrhea, Rise in Cases 663
Gramm-Rudman and STD Program 663
Gramm-Rudman, Effect of Sequestration 560, 561
Hemophilia-Related Activities 603
Herpes 588
Hospital Associated Infections 665
Immunization Budget, Childhood 630
Immunization of Adults 631
Immunization Levels, Improving 630
Immunization Program, Cost Effectiveness 657
Infant Mortality Initiative 613, 628, 660
Injury Control 617
Low Birth Weight 660
Low Birth Weight Infants by Smoking Status of Mother 557
Measles 553, 605
NIOSH Criteria Documents 615
NIOSH Employment 615
NIOSH Goals 614
NIOSH Recommendations to Department of Labor 666
NIOSH Scientists 616
NIOSH, Occupational Health Surveillance System 615
NIOSH, Ten Leading Work-Related Diseases and Injuries 556
New Initiatives 650
Nutrition Budget and Staffing 607
Nutrition Monitoring Plan 649
Nutrition Surveillance 606
Pertussis 606
Polio Vaccine Options 591, 592
Preventon Centers 594, 653
Rape Prevention and Services 667
Rescissions Proposed 570, 571
Reye's Syndrome 667
STD, Laboratories Monitoring and Tracking 638
STD Curricula in Medical Schools 640
STD Incidence 588, 645
STD Training 640

1014

	Page
Syphilis and Gonorrhea Transmission	587
Syphilis, Reported Cases of Primary and Secondary	554
Toxic Waste Exposure	605
Trauma Research	618
Tuberculosis Conference	658
Tuberculosis Cooperative Agreements	652
Tuberculosis Rates/Cases	585, 623, 635, 652, 659
Tuberculosis, Elimination of Grants	585, 633, 645, 647
User Fees for Proficiency Testing	667
Vaccinated—Number of Children in 1987	611
Vaccine Costs	611
Vaccine Liability Problems	612
Vaccine Shortages	612
Vaccine Stockpile	609, 631
Vaccine Stockpile, Current Status	656
Vaccine Stockpile, Funding	631, 657
Vaccine Stockpile, Sequestration	638
Vaccines Currently Stockpiled	606, 632
Vaccines, New	632
Violence Studies	626
Virology Laboratory Construction	618, 667
Virology Laboratory Equipment	623

Health Resources and Services Administration

Area Health Education Centers	16, 24, 66
Buildings and Facilities	51
Center for Nursing Research	12, 32
Community and Migrant Health Centers	63
Community Health Centers	16, 32
Community Health Centers Proposed Rescission	9
Consolidation of Administrative Funds	54
Disadvantaged Assistance	22, 66
Effects of Gramm-Rudman-Hollings Cuts	8
Employees Special Pay at Hansen's Disease Center	52
Equipment Costs and Controls	53
Facility Construction	17
Family Medicine and Internal Medicine	21
Family Planning	21, 58, 59, 62
Federal Employee Occupational Health	38, 82
Financial Distress	19, 57
Fiscal Year 1986 Proposed Rescission	8
Full-Time Employees	82
Geriatric Centers	18, 27
Geriatric Training	26, 68
Gillis W. Long Hansen's Disease Center	39
Gramm-Rudman-Hollings Reductions	11
Health Education Assistance Loans	26, 35, 80
Health Education Assistance Loans and Loan Guarantees	37
Health Education Assistance Loans Risk Sharing	35
Health Maintenance Organizations	20, 70
Health Personnel	22
Health Planning	19, 20, 23
Health Professions	17, 64, 76, 83
Health Professions Student Loans	35

Page
Hemophilia Projects 14
Home Health 63
Increased Cost in Administration 54
Infant Mortality 19, 57, 60
Loan Default Rates 36, 37
Loan Delinquencies and Defaults 15
Maternal and Child Health Block Grant 72, 85
Maternal and Child Health Set-Aside 24, 72
National Health Service Corps 10, 25, 33, 63
National Health Service Corps Placements 60
National Health Service Corps Scholarships 25, 63
Nurse Issues 84
Nursing Profession 69
Nursing Research 52, 87
Nursing Supply 12, 23, 25, 87
Nursing Supply and Demand 23
Opening Statement 2
Organ Transplant 10, 60
Proposed Expanded Primary Care Block Grant 20, 32
Proposed Reductions in Community Health Centers 9
Special Education Initiatives 18, 68
Travel Costs and Control 54
Tuskegee Syphilis Study 27
Uncompensated Care 27
User Fees 27, 38

○